Evaluation of PRM-Supported Initiatives on Mental Health and Psychosocial Support (MHPSS)

Evaluation Report – FINAL

U.S. Department of State, Bureau of Population, Refugees, and Migration

July 2022

This publication was produced at the request of the United States Department of State. It was prepared independently by EnCompass LLC.

Evaluation of PRM-Supported Initiatives on Mental Health and Psychosocial Support

Evaluation Report

U.S. Department of State, Bureau of Population, Refugees, and Migration

July 1, 2022

IDIQ Contract Number: D17PC00492

Technical and Advisory Services for Program Evaluation Requirements

Task Order Number: 140D0421F0739

Contact:

Name: Jonathan Jones, PhD
Title: Director of Monitoring, Evaluation, and Learning- EnCompass, LLC
Email: jjones@encompassworld.com

Team lead: Lynellyn D. Long, Ph.D.

Team members: Ted Rizzo, MEL Specialist; Gayatri Malhotra, MEL Specialist; Lane Benton, Project Coordinator; Kate Batchelder, MEL Specialist; Lauren Else, MEL Specialist; Sara Amhaz, Subject Matter Expert; Ari Cooper, Project Coordinator

EnCompass LLC
1451 Rockville Pike, Suite 600
Rockville, MD 20852
Tel: +1-301-287-8700

DISCLAIMER: The authors' views expressed in this publication do not necessarily reflect the views of the United States Department of State or the United States Government.

Table of Contents

ACRONYMS **7**

EXECUTIVE SUMMARY **10**

Background 10

Evaluation Purpose and Questions 11

Methodology 11

Findings/Conclusions/Recommendations 12

EQ1: Alignment of PRM-Supported Programs to Need *12*

EQ2: Accountability to Affected Populations *15*

EQ3: COVID-19 Impacts and Adaptations *17*

EQ4: PRM MHPSS Strategy *18*

DESCRIPTION OF MHPSS INITIATIVES **23**

EVALUATION PURPOSE AND SCOPE **27**

Evaluation Purpose 27

Evaluation Questions 27

EVALUATION DESIGN AND METHODOLOGY **28**

Evaluation Design 28

Methodology 29

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS **30**

EQ1: Alignment of PRM-supported MHPSS Programs to Need 30

EQ1: Findings *30*

EQ1: Conclusions *45*

EQ1: Recommendations *45*

EQ2: Accountability to Affected Populations 47

EQ2: Findings *47*

EQ2: Conclusions *52*

EQ3: COVID-19 Impacts and Adaptations 52

EQ3: Findings *53*
EQ3: Conclusions *60*
EQ3: Recommendations *60*
EQ4: PRM MHPSS Strategy 61
EQ4: Findings *62*
EQ4: Conclusions *74*
EQ4: Recommendations *75*
ALIGNMENT OF MHPSS INITIATIVES TO PRM'S FUNCTIONAL BUREAU STRATEGY 77
REFERENCES 79
ANNEXES 84
Annex 1: Country Specific Programming Recommendations 84
Turkey Programming Recommendations *84*
Bangladesh Programming Recommendations *88*
Annex 2: Evaluation Team 91
Evaluation Team *91*
Team Qualifications and Experience *91*
Annex 3: Evaluation Scope of Work 95
Background and Current Efforts *97*
General Task Order Terms and Conditions *115*
Annex 4: Detailed Methodology 119
Data Collection Design and Implementation *119*
Sampling *119*
Limitations *119*
Quantitative Data Collection *120*
Qualitative Data Collection *121*
Ethical Considerations *122*
Country Case Study Selection Criteria *122*
COVID-19 Safety Considerations *124*
Sample *125*

Recruitment *128*
Data Collection Procedures *131*
Procedures *134*
Data Security *139*
Data Analysis *142*
Anticipated Limitations and Mitigation Strategies *142*
Further Ethical Considerations *146*
Annex 5: Data Collection Instruments 151
Online Survey Tool *151*
Beneficiary – Focus Group Discussion Guide *176*
Beneficiary – Individual Interview *177*
NGO Programs (Onsite)– Individual Interview Guide *180*
UNICEF– Individual Interview Guide *182*
WHO– Individual Interview Guide *186*
Funders– Individual Interview Guide *189*
Annex 6: Desk Review Findings 192
Purpose *192*
Methodology *192*
Desk Review Findings across Evaluation Questions *195*
Evaluation Question 1: Targeting and Best Practice *197*
Evaluation Question 2: Integrating Service User Needs and Perceptions *210*
Evaluation Question 3: COVID-19 Pandemic Impacts *212*
Evaluation Question 4: Strengthening PRM's Strategy to Meet and Address Service User Needs *216*
Annex 7: Presenting Qualitative Data 218
Annex 8: Conflict of Interest Disclosures 220
Disclosure of Real or Potential Conflict of Interest for DoS Evaluations *220*
Disclosure of Conflict of Interest for DoS Evaluation Team Members *222*
Annex 9: Additional Survey Charts 240

Annex 10: PRM standard MPHSS Indicators for NGOs 278

ENDNOTES 279

Acronyms

Table 1: Acronyms

Acronym	Description
AAP	Accountability to Affected Populations
CBO	Community-based organization
CBT	Cognitive Behavioral Therapy
COR	Contracting Officer Representative
COVID-19	Coronavirus disease
CVT	Center for Victims of Torture
DOS	U.S. Department of State
EQ	Evaluation question
FGD	Focus group discussions
FY	Fiscal year
GBV	Gender-based violence
HQ	Headquarters
IASC	Inter-Agency Standing Committee
ICF	Informed Consent Form
ICRC	International Commitee of the Red Cross/ Cresent
IDPs	Internally displaced persons
IMC	International Medical Corps
IO	International organization
IOM	International Organization for Migration

Acronym	Description
IPV	Intimate partner violence
IRB	Institutional Review Board
JRS	Jesuit Refugee Service
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
MEAL	Monitoring Evaluation Assessment and Learning
MERS	Middle East Respiratory Syndrome
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
MOH	Ministry of Health
MSP	Minimum Service Package
NGO	Nongovernmental organization
NS	ICRC/IFRC National Societies
Peer+	Peer-to-Peer Plus
PFA	Psychological First Aid
PHC	Primary health care
PM+	Problem Management Plus
PoC	Populations of concern (refugees, migrants, internally displaced persons)
PPE	Personal protective equipment
PRM	Population, Refugees, and Migration
PSCs	Psychosocial Counselors
PSS	Psychosocial support

Acronym	**Description**
PTSD	Post-traumatic stress disorder
PwD	Persons with disabilities
S/GBV	Sexual and gender-based violence
SH+	Self-Help Plus
SRH	Sexual and reproductive health
UNHCR	United Nations High Commissioner for Refugees
USG	U.S. Government
WHO	World Health Organization

Executive Summary

Background

In mid-2021, the United Nations High Commissioner for Refugees (UNHCR) estimated that more than 84 million people were forcibly displaced worldwide. Some had faced traumatic experiences: bombardment, threats, captivity, torture, and injury. Most forcibly displaced people will experience grief, sadness, and loss. Forcible displacement disrupts everyday life, livelihoods, infrastructure, and social support systems. For a significant minority, such experiences trigger or exacerbate mental health conditions.

In 2021, approximately 86 percent of the Department of State Bureau of Population, Refugees, and Migration's (PRM) overseas assistance funding supported five major IO partners. The remaining 14 percent primarily went directly to international and local NGOs and community-based organizations (CBOs). As part of humanitarian and relief operations since 2018, four of the five IOs – International Committee of the Red Cross (ICRC), International Organization for Migration (IOM), United Nations High Commissioner for Refugees (UNHCR), and United Nations International Children's Emergency Fund (UNICEF)[1] – have provided MHPSS support through their own staff, international and local NGOs/CBOs, primary health care (PHC) clinics, and Ministries of Health (MOHs). PRM has supported programming that promotes integrating MHPSS interventions across all program sectors (particularly health, protection, and education). With its direct funding to NGOs/CBOs, PRM also supports several unique, stand-alone expert interventions to identify and address gaps in services.

[1] PRM's fifth major partner is the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

Evaluation Purpose and Questions

The purpose of this evaluation is to support the development of PRM's MHPSS strategies. EnCompass evaluated PRM's MHPSS programming from 2018 – 2021 through the operations of the four IOs (ICRC, IOM, UNHCR, UNICEF) and the World Health Organizations (WHO), as well as NGOs receiving direct support through PRM or through IOs. The scope of work (SOW) had four high level evaluation questions (EQ), and 13 sub questions. The four evaluation questions are presented below. Sub questions are found in Annex 3.

1. To what extent have PRM-supported programs, both by IOs and NGOs, contributed to meeting the MHPSS needs of refugees and IDPs?
2. How have PRM partners integrated the needs and perceptions of beneficiaries of PRM-funded programs into the planning, development, and evaluation of MHPSS programming?
3. How has the COVID-19 pandemic affected the efficacy of MHPSS programming from PRM partners (both stand-alone and integrated)?
4. What changes or updates to PRM's MHPSS strategy would help strengthen the ability of PRM to meet and address the MHPSS needs of its PoC?

Methodology

To understand the depth and breadth of PRM's portfolio, the Evaluation Team reviewed PRM's portfolio of 145 NGO files covering program proposals and reports across 25 countries. Team members also consulted with four of the five IOs (IOM, UNHCR, UNICEF, and WHO) and four INGO partners - Center for Victims of Torture (CVT), Hebrew Immigrant Aid Society (HAIS), International Medical Corps (IMC), and Jesuit Relief Services (JRS), working in MHPSS. The four IOs and NGOs provided an overview and background on their work. All five IOs, including ICRC, and the four NGOs provided and/or recommended key documents, which were reviewed in the Inception Report. The team also summarized MHPSS literature, primarily related to the

Interagency Standing Committee (IASC) policy guidelines and recommended practices. Findings from the consultations, portfolio and literature reviews informed the design of an online survey distributed from February to May 2022 to 43 NGO headquarters, who then forwarded the survey to their field programs. The survey yielded a response rate of 48 percent. In March 2022, the Evaluation Team interviewed service providers and users, including refugees, migrants, and asylum seekers in Ankara, Gaziantep, Sanliurfa, Izmir, and Istanbul. Service users included Syrians, Afghans, Iraqi, Iranians, and an Ivorian. In April 2022, the EnCompass team interviewed service users, the Rohingya, locally affected Bangladeshis, and providers in eight camp sites in Cox's Bazar and in Dhaka, Bangladesh. Qualitative data collection consisted of in-person and hybrid individual interviews and focus group discussions (FGDs). There was a total of 89 qualitative data collection events.

Findings/Conclusions/Recommendations

EQ1: Alignment of PRM-Supported Programs to Need

Findings

- IO and NGO staff in Geneva, Brussels, Turkey, and Bangladesh and service users in Turkey and Bangladesh reported that service users have a broad range of MHPSS needs, from anxiety driven by difficulties meeting basic needs to acute, clinical disorders. Many drivers of MHPSS needs came from limited ability to meet basic needs and lack of community supports.

- PRM-funded IOs and NGOs frequently integrate social and psychological considerations in the provision of basic services and security and work to strengthen community and family supports. They provide some focused, non-specialized support (e.g., basic mental health care by a PHC doctor or basic emotional support through community workers). In some cases, NGOs provide clinical services by mental health specialists (e.g., psychiatrists, clinical psychologists, and psychiatric nurses), but most clinical services are

provided through referral to national health care facilities when those facilities are accessible to PoCs. IOs and NGOs primarily integrated their programming through the humanitarian sectors but there are some standalone programs that respond to focused or clinical needs.

- PRM-funded NGOs report frequently implementing Psychological First Aid (PFA), Problem Management Plus (PM+), Cognitive Behavioral Therapy (CBT), Self-Help Plus (SH+), and Peer-to-Peer Plus (Peer+).[EQ 1] IO and NGO respondents in Geneva, Brussels, Turkey, and Bangladesh had generally found these programs useful when applied as designed but noted that consistency in training and supervision of implementers was sometimes a challenge.

- In both Turkey and Bangladesh, both service providers and users reported that the MHPSS services alleviated users' symptoms and provided them with valuable information and techniques. Service users noted that trust building, both between them and providers and between them and other group members, made treatment effective.

- IOs in Geneva and Brussels stated the importance of working within existing health care systems while flagging challenges, including legal barriers, differences in understanding of MHPSS between host governments and implementers, and limited numbers of qualified MHPSS professionals. IOs and NGOs in Turkey and Bangladesh discussed how these challenges led to gaps in services and ways they worked to counteract these gaps.

- Several populations faced MHPSS service gaps. Persons with disabilities (PwDs), people on the move, rural people, older people, and men, may have had services available, but the services did not fully meet their needs or reach all population members. Other groups, such as LGBTQI+, do not always have access to services targeted to their specific needs, though they may access services that are not targeted to their needs.

- IO staff members identified several challenges to tracking cost effectiveness. The extent to which organizations evaluate the cost-effectiveness of their interventions is limited.

- U.S. Government (USG), IO, and NGO staff in the case study countries all noted that shifting priorities and the resulting program close out have caused harm when other services are not readily available to receive people who continued to need these services.

Conclusions

- PRM-funded IO and NGO programs respond to MHPSS needs ranging from integrating MHPSS interventions into basic services to offering clinical services by mental health specialists. Most MHPSS services focused on integration into basic services, strengthening community and family supports, and, to a lesser extent, on focused, person-to-person non-specialized support. PRM-funded programs provide limited clinical services beyond referrals. Service users benefit from both standalone and integrated programs. [EQ 1a, 1b, 1c]

- Due to the challenges of integrating with existing health care systems in low resource settings, the limited number of MHPSS professionals and supervisors relative to the demand, and the broad range of mental health challenges that service users face (further driven by limited access to basic needs and education), there are mental health gaps, particularly for person-to-person services, both clinical and non-clinical, that PRM-funded programs could not fully address, despite efforts to support focused person-to-person non-specialized and clinical care. [EQ 1a, 1d]

- Overall, PRM's approach to MHPSS service provision appears to work well for those service users who programs can reach. Referral pathways for clinical services (both inside and outside of camps) need to be strengthened in coordination with other MHPSS partners and primary health centers. To increase existing programs' impact and improve access to clinical services by mental health specialists, the number and capacity of qualified MHPSS professionals, both medical and non-medical, needs to be increased. [EQ 1d, 1e]

Recommendations

- To address staffing shortages, PRM should prioritize programs that build the capacity and skills of MHPSS professionals, particularly those who can train staff and community members to refer those with MHPSS needs to PHCs. Many PHC clinical staff in turn need further training to provide clinical services or referrals to higher level services. Programming could encourage relicensing and training new MHPSS professionals from the service user population so that they can practice in their new countries and reduce staffing shortages. To the extent possible, PRM should encourage NGOs to support a diverse range of practitioners and volunteers. [EQ 1d].

- Over the next several years, PRM should engage in targeted advocacy with host governments to facilitate service users' entry into the labor market (and children's entry into education) to reduce stressors that drive MHPSS concerns. [EQ 1d].

- PRM should require their grantees to develop explicit, rapid close out strategies and plans (e.g., training and transferring services to local providers and communities) to ensure sustainability and continuity of services for service users and fund short term implementation of these strategies when grants are not renewed. [EQ 1d].

EQ2: Accountability to Affected Populations

Findings

- Reported feedback mechanisms in Turkey and Bangladesh consisted of hotlines, complaint boxes, and direct feedback, both in individual and group settings. Service users reported that having multiple feedback mechanisms allowed for confidential and sensitive feedback.

- IOs and NGO reported that feedback mechanisms are accessible for children and in formats reducing language and literacy obstacles for service users. Service users and

NGOs indicated that mechanisms are offered in confidential and anonymous formats, which encourage open feedback.

- Program content was adapted or developed to respond to service user needs (e.g., programs for language skills, livelihoods, and sessions on S/GBV, family dialogue, and depression), which were identified through feedback mechanisms. Logistical adaptations (e.g., in scheduling, location, and materials provision), were addressed to reduce barriers to service user participation.

- While respondents provided positive examples of involving service users' feedback in decision-making, service users reported persistent gaps in information in order to make connections to other service organizations and barriers to services including shortages of same-gender staff.

Conclusions

- The current feedback systems used by IOs and NGOs capture service user input and are generally effective at incorporating service user feedback to design and implement MHPSS programming relevant to the service users' needs. However, IOs and NGOs are aware of populations who face gaps in accessing services and whose needs are not then addressed in programming approaches. The data provide strong evidence that service users have access to a variety of feedback mechanisms. The mechanisms are appropriate for gathering information on sensitive topics as well as accessible for service users of various ages and literacy skills. [EQ 2a] In response to feedback, service users report that programs were adapted to ease logistical barriers and to tailor programming to address MHPSS needs. The data indicate that while organizations incorporate beneficiary feedback, more could be done to reduce information gaps to connect users to other services.

EQ3: COVID-19 Impacts and Adaptations

Findings

- The COVID-19 pandemic increased the mental health burdens of service users and providers. Women and children are reported as facing specific vulnerabilities from IPV and S/GBV, social isolation, and lack of access to education.

- PRM's flexible funding allowed organizations to adapt to the COVID-19 pandemic.

- Adaptations to the COVID-19 pandemic included training of service providers from the local population, virtual service provision and supervision, further integrated services, and an increased focus on livelihood and food programming. Adaptations varied by country and target population.

- Virtual service provision provides wide reach and flexibility, especially for women and PwDs who may not be able to leave their home to receive services. However, it requires access to digital devices and risks not reaching people experiencing domestic violence and S/GBV.

- Implementers integrated MHPSS services into health services during the pandemic in order to respond to MHPSS needs including those pre-existing, amplified and/or driven by the pandemic.

- As the burden on staff and service providers increased, additional support was needed, including training of more MHPSS service providers. Existing providers needed support to cope with loss and address their own stresses, secondary stress, and burnout.

Conclusions

- The COVID-19 pandemic had positive and negative effects on MHPSS. While isolation increased MHPSS needs, the pandemic also led to more MHPSS conversations online and community-led support. Seeking services became more normalized and virtual

service provision increased access to care for many. Some groups experienced increased needs and did not receive services in-person or virtually. Implementing staff and beneficiaries alike were most interested in hybrid services moving forward.

- The pandemic brought to light the needs of MHPSS service providers. Reports of burnout, high turnover, increased stress, and increased secondary stress demonstrated the need for more trained service providers and the importance of self-care interventions for service providers.

Recommendations

- Over the next funding cycle, PRM should work with its IPs to determine where and when hybrid approaches will and will not be feasible and advisable and work to develop these approaches. [EQ 3a, 3b]

- PRM should ensure that future funding allows for ongoing self-care interventions for mental health professionals and volunteers. [EQ 3b]

- PRM should ensure that future funding allows for ongoing self-care interventions for mental health professionals and volunteers. [EQ 3b]

EQ4: PRM MHPSS Strategy

Findings

- Including MHPSS in PRM's health strategy reinforced the understanding that addressing mental health is an intrinsic (sine qua non) part of humanitarian health care.

- Including MHPSS in PRM's health strategy reinforced the understanding that addressing mental health is an intrinsic (sine qua non) part of humanitarian health care.

- In addition to health, service providers most often referenced the protection (including child protection and S/GBV), education, livelihoods, and nutrition sectors as critical to

MHPSS integration and their sectoral operations. In face of funding cuts, they were also concerned that MHPSS interventions could be deprioritized by sector specialists.

- Accountability to Affected Populations (AAP) was well documented by PRM's NGOs, and many IPs developed strategies to include PwDs. AAP measures led to partners developing new strategies for MHPSS provision (e.g., mobile clinics, online programming, and community volunteers).

- Being accountable did not guarantee that partners were able to access the most affected and vulnerable service users, particularly during the pandemic. Some of the documented barriers were logistical (internet coverage and distances), service users' lack of legal status, and socio-cultural (stigma towards LGTBI+, religious, and familial statuses).

- PRM increased support to its IPs through multi-year funding and added new partnerships with national and local NGOs.

- PRM's MHPSS milestone, "increased engagement between PRM and WHO on MHPSS to enhance programming," was not realized during the programing period that was in scope for this evaluation (2018-2021). However, PRM continued to be perceived as a major donor in advancing MHPSS humanitarian programming, knowledge, and innovation. WHO and other IOs indicated that PRMs participation as an observer would be very welcome on MHPSS country level Technical Working Groups (TWGs) and at the global level MHPSS IASC Reference Group (RG), currently co-chaired by WHO and IFRC.

- Implementing partners' monitoring and evaluation systems characteristically did not address outcomes (other than self-reported) 14 and impact data, which were reported to be difficult to obtain within limited time frames and pandemic lockdowns.

- IPs, particularly for their cross-sectoral operations, lacked systems to track MHPSS expenditures and in general, there was little to no financial analysis of interventions and programming. IPs, particularly for their cross-sectoral operations, lacked systems to

track MHPSS expenditures and in general, there was little to no financial analysis of interventions and programming.

- There was a widespread perception of a tradeoff between addressing the severity and the magnitude of mental health needs.

- Most IO and NGO programs, whether integrated across sectors or standalone programs, lacked sufficient MHPSS human resources and capacity to address the increased demands at all levels of the pyramid, particularly during the pandemic, where basic survival needs were not being met in some cases.

- IPs reported that national health care systems were under-resourced and challenged particularly during COVID-19. IPs reported that there was not enough medical training of clinical psychologists and psychiatrists, who in turn could train PHC providers to recognize and refer mental health conditions. Some countries had very few clinicians (e.g., one country had only one psychiatrist). Given the increased demands for mental health services in northern countries, health care migration of psychiatrists and other critical providers to those countries reportedly increased.

- In spite of their tragic nature, and notwithstanding the human suffering they create, emergency situations are also opportunities to build better mental health care" (WHO 2013:4). The opportunity and the necessity to implement WHO's "Build Back Better" remain equally relevant today.

Conclusions

- PRM's strategy addresses relevant concerns about the role of mental health in health care provision, but simply as a health strategy does not capture the Bureau's critical cross-sectoral support, particularly related to protection, education, livelihoods, and nutrition. [EQ 4a]

- PRM has the experience, international reputation, and tiered- and multi-year funding modalities to advance the MHPSS agenda on international and national levels; to advocate, where possible, for PoC's inclusion in national health care and social welfare systems; and to strengthen donor coordination on the MHPSS technical working groups. [EQ 4b]

- AAP measures were most effective in encouraging new programming strategies. However, service users' experiences and requirements are best captured through locally and culturally adapted, outcome and impact measures that reflect IASC's (2021) "Common M&E Framework to implement the Core Principles of: Human rights and equity, Participation, Do no harm, Integrated services and supports, Building on available resources and capacities, and Multilayered supports. [EQ 4c]

- Monitoring and evaluation systems, lacking financial, outcome, and impact metrics, are insufficient for strategically allocating resources, making the case for the cost effectiveness of community-based interventions, and determining how to integrate with national health care systems and to go to scale most efficiently. [EQ 4c]

- Given a rapidly evolving field with reported high health care provider turnover and migration rates and language and cultural differences, and secondary stress, existing human resources—specifically trained mental health and PSS service providers—are insufficient to address the needs and expectations at every level of service provision across diverse populations and to go to scale through national integration. [EQ4]

Recommendations

- PRM's MHPSS strategy would benefit from updates to reflect the Bureau's PSS community-based and cross-sectoral programming, COVID-19 adaptations, and expected funding modalities, outcomes, and impact. [EQ 4a, 4c].

- Groups to support and coordinate with other donor, IO, and NGO/CBO strategies for rolling out the Minimum Service Package (MSP) and for integrating MH and clinical

psychological services in national health care systems, and psychological and social support in national and community social welfare systems. [EQ 4b, 4c].

- PRM should encourage its NGOs, through its AAP requirements, to develop specific, local strategies for accessing the hardest to reach. [EQ 4].

- To the extent possible, PRM should encourage its IPs to organize monitoring and evaluation systems that address outcomes and impact with some basic cost and expenditure data, and to use the IASC M&E framework. [EQ 4c].

- PRM should encourage its IPs to develop some simple benefit-cost analysis to assist in determining where best to target limited resources in a given population based on the PoC profiles, needs, infrastructure availability, and existing resources. [EQ 4c].

- PRM should prioritize support at all levels for IPs that address human resource requirements from training community-based volunteers to re-credentialing refugee psychiatrists and/or training for national and local psychiatrists, clinical psychologists, psychiatric nurses, and PHC clinicians in addressing humanitarian mental health needs. Strengthening the human resource base may be the most effective way of expanding the integration of refugee populations into host government health care and social welfare systems. [EQ 4b, 4c].

Description of MHPSS Initiatives

In mid-2021, the United Nations High Commissioner for Refugees (UNHCR) estimated that more than 84 million people were forcibly displaced worldwide, including 48 million internally displaced, 26.6 million refugees, and 4.4 million asylum seekers[a] . Some faced traumatic experiences: bombardment, captivity, torture, and injury[b]. Those escaping war and conflict may have witnessed torture, death and/or injury of family and friends[c]. Once displaced, many risked economic hardships, discrimination, loss, and/or social isolation[d]. Daily stressors and the uncertainty about one's future in protracted emergencies and conflicts could also affect their mental and psychological well-being and mediate or heighten the impact of earlier traumatic events[e]. In 2020, the COVID-19 pandemic exacerbated these hardships with border closures; losses of livelihoods; limited to no access to health, education, and other basic services; and in extreme cases, insufficient food supplies, potable water, sanitation, and/or shelter[f].

Most forcibly displaced people will experience grief, sadness, and loss. Acute transient distress is a natural response to extreme adversity[g]. Forcible displacement disrupts everyday life, livelihoods, infrastructure, and social support systems. For a significant minority, such experiences trigger mental disorders, including depression, post-traumatic stress, substance abuse, and/or grief. These disorders can undermine people's functionality to address everyday tasks. Those with pre-existing conditions, including psychosis, epilepsy, and Alzheimer's, may require increased support when basic health and social services are stretched or nonexistent. Given pressures on families and households, sexual and gender-based violence (S/GBV) may increase. S/GBV in turn contributes to long-term and inter-generational suffering and loss of social cohesion. A 2019 World Health Organization (WHO) prevalence study finds that:

> *The burden of mental disorders is high in conflict-affected populations. Given the large numbers of people in need and the humanitarian imperative to reduce suffering, there is an urgent need to implement scalable mental health interventions to address this burden.*

The WHO estimates that rates of depression, post-traumatic stress disorder (PTSD) and any mental disorder among people exposed to conflict in the previous 10 years were 10.8 percent,

15.3 percent, and 22.1 percent respectively.[h] Emergencies, conflicts, and natural disasters increase the prevalence of mental health and psychosocial distress in those directly affected; secondary trauma in those providing humanitarian and emergency assistance; and insecurity, anxiety, and instability in surrounding locally affected families and communities. Given these stressors, the humanitarian community recognizes the importance of providing "mental health and psychosocial support" (MHPSS) programming, defined as "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder."[i]

The humanitarian community, including international organizations (IOs), nongovernmental organizations (NGOs), and community-based organizations (CBOs), and governments has increasingly recognized the need to address MHPSS in their programming for refugees, displaced persons, migrants, stateless persons, and all "persons of concern" (PoCs). In 2021, approximately 86 percent of the Department of State Bureau of Population, Refugees, and Migration's (PRM) overseas assistance supported five IO implementing partners (IPs): the International Committee of the Red Cross (ICRC), the International Organization for Migration (IOM), the UNHCR, the United Nations International Children's Emergency Fund (UNICEF), and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).[2] As part of their humanitarian and relief operations, these IOs provide MHPSS through their own staff, NGOs/CBOs, primary health care (PHC) clinics, and Ministries of Health (MOHs).

For PRM's evaluation of its MHPSS support, the Bureau asked EnCompass, LLC to address PRM's programming from 2018 – 2021 through the work and operations of five IOs (ICRC, IOM, UNHCR, UNICEF, and WHO). These five IOs either directly received PRM funding for MHPSS programming (ICRC, IOM, UNHCR, and UNICEF) or in the case of the WHO, led in MHPSS

[2] Data provided by PRM in November 2021

humanitarian programming. All five IOs work in direct and prolonged conflicts and emergencies with “populations of concern” (PoCs), who may have heightened MHPSS needs.

PRM’s MHPSS support to its IO/IPs is predicated on each organization’s strengths, expertise, and focus areas. UNHCR integrates MHPSS into their programming, mainly within health, community-based protection, and S/GBV and child protection. They support capacity building, operational research, and training and integration of MHPSS services into national health care systems for refugees. ICRC identifies, trains, and supports first responders, including community leaders, to provide MHPSS services to individuals and groups in emergencies and situations of armed conflict. IOM provides psychosocial mobile teams; psychoeducational, nonformal education and recreational activities; MHPSS hubs in camps and host communities; and reintegration training and services for returnees.

UNICEF and the WHOreceive most of their U.S. Government MHPSS funding from other agencies. However, given their leadership roles in MHPSS, their work is included in this evaluation. WHO supports epidemiological research, identifies gaps in services and ways to respond, develops training guidelines for MOH/PHC providers, and provides evidence for new therapies, best practices, and case management. WHO and IFRC currently co-chair the Inter-Agency Standing Committee (IASC) Reference Group on MHPSS in Emergency Settings. UNICEF supports MHPSS services for children, families, and other caregivers through its child protection/GBV, education, health, nutrition, and water, sanitation, and hygiene (WASH) sectors’ programming. WHO, UNICEF, UNHCR, and UNFPA have also developed a Minimum Service Package (MSP), funded by multiple donors. The MSP is being piloted in five countries: Colombia, Iraq, Nigeria, South Sudan, and Ukraine, to set a standard for MHPSS service delivery in humanitarian situations.[j]

In addition to supporting the IOs’ to organize MHPSS services, PRM provided direct assistance through cooperative agreements globally to over 135 NGOs and CBOs at regional and country levels. In this evaluation, PRM prioritized four NGOs—the Hebrew Immigrant Aid Society (HIAS), International Medical Corps (IMC), Jesuit Refugee Service (JRS), and Center for Victims of

Torture (CVT)—given their focus on MHPSS programming across several countries.[3] CVT has worked with torture and trauma survivors for several decades. CVT, HIAS, JRS, and IMC have provided specialized training and support for referral pathways to primary health care system. As recognized leaders in MHPSS to PoCs, they and other NGOs (referenced in this evaluation) have developed both standalone and integrated cross-sectoral MHPSS programming.

Guided by IASC's MHPSS intervention pyramid (refer to Exhibit 1), PRM has supported programming at all four programming levels. PRM's funding for its IPs (IOs and NGOs) promotes integrating MHPSS interventions across all program sectors (particularly health, protection, livelihoods, nutrition, and education). PRM supports several unique, stand-alone expert interventions (e.g., guidelines, specialized mobile teams, and clinical training) to identify and address service gaps.

Exhibit 1: IASC Pyramid of MHPSS Needs

Full image description—Pyramid in four sections from top to bottom:

- Clinical services (e.g., clinical mental health care)

[3] These four NGOs were instrumental in the consultations for the Inception Report. Although they were not included in our case study countries, their insights guided the data collection.

- Focused psychosocial supports (e.g., basic emotional and practical support to selected individuals or families
- Strengthening community and family supports (e.g., activating social networks and supportive child-friendly spaces)
- Social considerations in basic services and security (e.g., advocacy for good humanitarian practice: basic services that are safe, socially appropriate, and that protect dignity)

Evaluation Purpose and Scope

MHPSS programming is critical to PRM's mandate "to provide life-saving assistance and protection to the world's most vulnerable people."[k] PRM's aim is to increase access to MHPSS services to build resilience among PoCs.

Evaluation Purpose

To date, PRM has not evaluated its MHPSS programming. The Bureau requires evidence to provide practical recommendations to inform its MHPSS strategy policies and programming for PoCs.[4] While this evaluation is largely retrospective, PRM requested that EnCompass conduct a formative evaluation of its current strategy and work on MHPSS going forward.

Evaluation Questions

The SOW had four evaluation questions and 13 sub questions. The evaluation questions are presented below. The sub questions are found in Annex 3.

1. To what extent have PRM-supported programs, both IO and NGO, contributed to meeting the MHPSS needs of refugees and internally displaced persons (IDPs)?

[4] For purposes of this evaluation, "persons of concern" (PoCs) may include refugees, migrants, internally displaced, asylum seekers, stateless, and/or locally affected populations.

2. How have PRM partners integrated the needs and perceptions of beneficiaries of PRM-funded programs into the planning, development, and evaluation of MHPSS programming?
3. How has COVID-19 affected the efficacy of MHPSS programming from PRM partners (both stand-alone and integrated)?
4. What changes or updates to PRM's MHPSS strategy would help strengthen the ability of PRM to meet and address the MHPSS needs of its PoC?

Evaluation Design and Methodology

The evaluation took place between October 2021 and July 2022. The team focused on PRM MHPSS programming from 2018 until 2021.

Evaluation Design

To develop the data collection instruments, the Evaluation Team held 14 consultations with four IOs, four NGOs, and PRM Program Officers and Refugee Coordinators in Washington, D.C., Geneva, Turkey, and Bangladesh. The interviewees provided documentation of their MHPSS actions, which informed the Inception Report. To capture the depth and breadth of PRM's portfolio, the team reviewed PRM's portfolio covering 145 IP proposals and reports across 25 countries (refer to Annex 6 for Inception Report Findings). The team also reviewed MHPSS literature, primarily related to IASC policy guidelines and recommended practices. The consultations, along with updates on the current political, refugee, and security situation led to selecting two fieldwork sites—Turkey and Bangladesh—from eight potential countries

identified by PRM (refer to Annex 4 for details).[5] Findings from the portfolio and literature reviews informed the online survey design.

In February 2022, two team members interviewed IOM and IMC MHPSS managers in Brussels and ICRC, UNHCR, and WHO managers and the U.S. Mission Team in Geneva.

In March 2022, the Evaluation Team interviewed service providers and users in Turkey: refugees, migrants, and asylum seekers, who included Syrians, Afghans, Iraqi, Iranians, and an Ivorian, in Ankara, Gaziantep, Sanliurfa, Izmir, and Istanbul. In April 2022, the EnCompass team interviewed service users—Rohingya refugees, locally affected Bangladeshis—and providers in eight camp sites in Cox's Bazar and in Dhaka, Bangladesh. Data collection included 89 individual interviews and focus group discussions (FGDs). The interviews from Bangladesh, Brussels, Geneva, and Turkey demographics are provided in Annex 4.

Methodology

MHPSS in the humanitarian context is a technical, rapidly changing field addressing potentially life-threatening issues. To capture these complexities, the Evaluation Team employed mixed methods: interviews and FGDs, literature and portfolio reviews, and an online survey. The team conducted 89 qualitative data collection events, including with providers and service users. 48 NGOs and 37 IOs were interviewed in Brussels, Geneva, Turkey, and Bangladesh, and the team conducted three interviews with the local Bangladeshi community. The survey was distributed to 43 NGOs with a response rate of 48 percent. Further details on methods are in Annex 4.

[5] The eight countries were: Bangladesh, Colombia, Ecuador, Jordan, Kenya, South Sudan, Thailand, and Turkey.

Findings, Conclusions, and Recommendations

EQ1: Alignment of PRM-supported MHPSS Programs to Need

Evaluation Question: To what extent have PRM-supported programs, both IO and NGO, contributed to meeting the MHPSS needs of refugees and IDPs?

The findings below address programs' alignment to needs and international best practices; the effectiveness of standalone programs as well as efforts to integrate MHPSS into other sector responses; how well PRM-supported NGO activities addressed gaps in IO programming to meet MHPSS needs; and which activities were more or less successful in meeting goals.

EQ1: Findings

IO and NGO staff in Geneva, Brussels, Turkey, and Bangladesh and service users in Turkey and Bangladesh reported that service users have a broad range of MHPSS needs, from anxiety driven by difficulties meeting basic needs to acute, clinical disorders. Many drivers of MHPSS needs came from limited ability to meet basic needs and lack of community supports.

As one NGO frontline worker in Turkey reported, "sometimes the financial difficulties may be the first cause of psychological issues." Reflecting this, service users report difficulties in paying for food and lodging as a source of stress. Similarly, discrimination, bullying of children, a lack of cultural integration, and loss of connections with friends, family, and community led to stress, depression, and anxiety. Across both countries, women and men highlighted stress arising from the challenges of living in a new country. One male refugee in Turkey noted, "to be a 'refugee' is to be stressed." While reportedly less prevalent, respondents also observed that some

service users required clinical care for pre-existing mental conditions (e.g., bipolar disorder, PTSD, and suicidal ideation), which may have been caused or exacerbated by their displacement.

Twenty-six PRM-funded NGO survey respondents identified clinical disorders to which their programs respond. The four disorders to which they often respond are depression (n=25, 96 percent), PTSD (n=24, 92 percent), anxiety disorder (n=23, 88 percent), and grief (n = 23, 88 percent). These respondents also indicated their programs sometimes address suicide ideation and mental disorders in children. Additionally, 27 NGOs identified different population-specific needs to which their programming responds, including S/GBV survivor support needs (n = 25, 93 percent), disability support needs (n = 25, 93 percent), intimate partner violence (IPV) survivor support needs (n=24, 89 percent), torture survivor support needs (n = 21, 78 percent), and Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI+) support needs (n = 14, 52 percent) (Exhibit 4 in Annex 9). These responses indicated programming targeted victims of S/GBV and IPV, children, and persons with disabilities (PwDs). While people of all genders may be S/GBV and IPV survivors, most service providers noted that they primarily serve female victims of these forms of violence, and, according to service providers in both Turkey and Bangladesh, as seen globally, more women than men access MHPSS programming overall.[l]

PRM-funded IOs and NGOs frequently integrate social and psychological considerations in the provision of basic services and security and work to strengthen community and family supports. They provide some focused, non-specialized support (e.g., basic mental health care by a PHC doctor or basic emotional support through community workers). In some cases, NGOs provide clinical services by mental health specialists (e.g., psychiatrists, clinical psychologists, and psychiatric nurses), but most clinical services are provided through referral to national health care facilities when those facilities are accessible to PoCs. IOs and NGOs primarily integrated their programming

through the humanitarian sectors but there are some standalone programs that respond to focused or clinical needs.

IO headquarters (HQ) staff observed the importance of the MHPSS response system working at all four levels of the IASC pyramid and coordinating work across providers to ensure coverage at all levels. One IO staff member in Geneva advised, "we need to focus on referral pathways and have a memorandum of understanding with other organizations who can provide services to other areas of the pyramid." In some countries, PRM-funded programs work with national health services to ensure this coverage. In Turkey, clinical services are provided through secondary and tertiary national care and some non-specialized services through primary health care. While working with national health services to provide coverage can help achieve scale and avoid creating parallel structures, effectiveness may vary depending on the capacity of the national service to take on the additional population. In Turkey, PRM funded some centers that integrate MHPSS services into other programs but concurrently offer standalone one-on-one non-specialized services. Service users generally have a high regard for these standalone services compared to government services. A female service user in Turkey said, "the migrant health center sometimes provides services, but they are not similar to the services here [at the PRM-funded center]. The services here are broader, and the care of the patients is more [here] than there." This preference may indicate a gap in mental health care given the reliance on government MHPSS services to respond to clinical needs. In Bangladesh, government health services outside the camps, remain difficult for Rohingya refugees to access.[6]

Due to the central importance of referrals, service providers reported training social workers, physical therapists, other non-MHPSS technical staff, receptionists, and sometimes even drivers on making referrals. In Turkey, one NGO provided referral trainings to other NGOs and to

[6] A UNHCR staff member reports that there are ongoing discussions to provide telemedicine services and enhancing mental health capacity in health facilities within the district (reported in June, 2022).

teachers in public schools attended by both Turkish and refugee children. In Bangladesh, the IOs and NGOs trained community para-counseling volunteers to provide basic MHPSS services.

PRM-funded programs focus on integrating MHPSS programming with services to address basic needs and protection or to strengthen community supports. A NGO HQ staff member in Bangladesh advised, "if we don't address this issue in the beginning, then slowly, slowly it will change into the mental health illness." An NGO frontline staff member in Turkey observed:

> *As much as you offer services at the basic level of the pyramid, you decrease the need for the higher level. At each level of the pyramid, as you address the challenges you reduce the need at the next level.*

An IO frontline staff member in Turkey explained that "when we talk about mental health, they talk about how being unable to find a job affects their mental health." Service users echoed this concern and prioritized programs that could also meet basic needs. Service providers in Turkey and Bangladesh believed that often men may not attend MHPSS programs because they are focused on finding work and meeting families' basic needs.

Respondents observe that MHPSS integration into other sectors is critical, and many PRM-funded programs are already integrated. In the survey, NGO respondents were asked about a series of activities and whether they implemented these activities as "standalone" or "integrated." Integrated activities were consistently more common than standalone ones, including individually focused services. These NGOs reported that they frequently integrate activities into the protection (including GBV) and health sectors, with some integration into education. These same sectors were the most frequently mentioned in the Turkey and Bangladesh interviews, along with livelihoods and nutrition. Some IO and NGO staff said that integration had proceeded well, while others observed more could be done, particularly in sharing data across MHPSS programs integrated into different sectors.

Service providers see integration as important in a holistic response to many MHPSS challenges but less effective to meet specialized needs. As an IO Geneva manager observed:

Integration is excellent. The problem is that sometimes you have people with severe issues, and it is hard with clinics of few doctors…and that doctor has so many other patients…so having a dedicated person is important… In large operations, there is a place for specialized services that cannot easily be integrated in other more generic services.

Respondents indicated that PRM-funded integrated and standalone programs were both effective for participants who access those programs. However, given the reliance on government health sector referrals at level four, some critical needs may not be adequately met for service users who need level four services.

PRM-funded NGOs report frequently implementing Psychological First Aid (PFA), Problem Management Plus (PM+), Cognitive Behavioral Therapy (CBT), Self-Help Plus (SH+), and Peer-to-Peer Plus (Peer+).7 IO and NGO respondents in Geneva, Brussels, Turkey, and Bangladesh had generally found these programs useful when applied as designed but noted that consistency in training and supervision of implementers was sometimes a challenge.

NGOs survey respondents reported the psycho-social interventions they use in their PRM-funded programs. The most frequently cited responses are shown in **Error! Reference source not found.**Table 2, while the full range of responses appears in Exhibit 10 in Annex 9.

Table 2: Percentages of NGOs reporting the use of various psycho-social support interventions

Support interventions	PFA	PM+	CBT	SH+	Peer+
Percentage of NGOs that use therapy (overall)	**89**	**71**	**71**	**64**	**57**

[7] Both PM+ and SH+ are brief packages with adapted techniques derived from CBT (UNHCR observation, June 2022).

Support interventions	PFA	PM+	CBT	SH+	Peer+
Percentage of NGOs that use therapy with both individuals and groups	72	50	43	46	21
Percentage of NGOs that use therapy with individuals only	21	18	29	4	14
Percentage of NGOs that use therapy with groups only	4	4	0	4	14

Most PRM-funded NGOs that used these interventions used them to address PTSD, anxiety disorders, depression, and suicide ideation.

In Turkey and Bangladesh, IO and NGO respondents cited positive experiences with the interventions, with some caveats. For example, in Bangladesh service providers trained community para-counselor volunteers on PFA to serve as first responders for natural disasters and other adverse events. However, country-level IO HQ staff members observed that para-counselor volunteers' PFA training varied. In some cases, there was insufficient oversight of the training and follow-up due to the limited number of trained professionals who could supervise the para-counselors. Staff were concerned about whether the counselors implemented PFA according to its intended uses. An IO HQ staff member in Bangladesh observed:

> *It's not that we disagree with Psychological First Aid, but in some understanding, is that we sometimes perceive it to be a one-time thing. With Psychological First Aid, often, this can be used in emergency settings, for example, so you look, listen, and link, so then you package the person off, and then that's it.*

Both PM+ and SH+ have been trialed with Syrian refugees in Turkey. SH+ was found to reduce the incidence of mental disorders six months following treatment among refugees.[m] For PM+, Syrian refugees both stayed in the program and reported that they appreciated the content, format, and implementation of the intervention.[n] IO respondents in Geneva and Brussels

advised that PM+ and similar interventions do not address severe or complex mental health conditions and should include follow-up support to be most effective.

NGOs in Bangladesh reported using Integrative Adapt Therapy (IAT), a theoretically guided approach based on the Adaptation and Development After Persecution and Trauma (ADAPT) model, specific to the refugee experience. An IO Bangladesh staff member explained that research evidence shows that IAT has effective outcomes with this population.[o]

In both Turkey and Bangladesh, both service providers and users reported that the MHPSS services alleviated users' symptoms and provided them with valuable information and techniques. Service users noted that trust building, both between them and providers and between them and other group members, made treatment effective.

Service users in both Turkey and Bangladesh stated that they had found PRM-funded MHPSS programs useful because the treatment they received had alleviated symptoms of depression, anxiety, and stress and, in some cases, even suicidal thoughts. They appreciated the opportunity to share their feelings, even when they could not access medication, and reported that staff were very attentive and good listeners, which helped to build trust. In Turkey, some service users described both service providers and other group participants as family. One male service user noted, "we created friends we didn't know in the past. They are like family. Now we communicate with each other and solve each other's problems."

While both service providers and service users described the benefits of individual and group treatment, they mainly discussed group activities. Respondents highlighted the ways that group activities helped them. At the most basic level, information sessions (in both countries) and language classes (in Turkey) allowed service users to learn about and access basic services. Group activities also served to build social connections, both between service users and with the host community. These social connections persisted after the group sessions, with service users often maintaining group WhatsApp channels to remain in touch. Additionally, group participants described activities that helped to reduce stress and alleviate symptoms when

focused on a particular mental health issue. Frontline service providers tailored specific group activities to what participants requested. They used recreational activities such as music, pottery, cooking, and henna, to engage service users and identify future activities to target more complex needs. The providers also reported that service users who became leaders through the groups were invaluable in identifying and recruiting other community members with MHPSS needs and who could benefit from future activities.

Service providers advised that their work to assure buy-in with local-level host governments and community leaders was a driver of success in their programming. Linking with these leaders increased trust in and awareness of the programs and improved service providers' ability to identify and respond to cases. Turkey IO staff reported that working with local governments allowed them to show the benefits of including host populations in programming, which helped to reduce community tensions. In both countries, service providers stated that working with local NGOs or with religious leaders could help to destigmatize mental health.

> *We got a suggestion from beneficiaries, especially the religious leaders, they give us the suggestion to speak our message or to have awareness session and psychosocial support sessions using the Islamic songs or using the Islamic words. We can reach the people who thinks that the NGOs were against religion. – IO frontline staff member in Bangladesh*

IOs in Geneva and Brussels stated the importance of working within existing health care systems while flagging challenges, including legal barriers, differences in understanding of MHPSS between host governments and implementers, and limited numbers of qualified MHPSS professionals. IOs and NGOs in Turkey and Bangladesh discussed how these challenges led to gaps in services and ways they worked to counteract these gaps.

In Geneva and Brussels, IO managers observed that MHPSS work is shifting to improve applicability of services and sustainability by working with locally based NGOs. These services, in turn, are increasing scale and sustainability by integrating with national health care systems. Local and national integration reduces duplication of services. The IOs do not want to create

parallel systems and focus on developing capacity within existing structures. While IO and NGO staff in Geneva, Brussels, and both case study countries see this as important, they recognize that working with local systems, particularly local governments, can create gaps in services.

One critical issue is that host governments are not always willing or able to integrate service users into their health system and put regulatory barriers in place that make access difficult for service users. The Bangladesh government allows Rohingya people access to services outside the camps when the level of care within the camps is insufficient. However, the process to obtain a permit to leave the camps is challenging for both service providers and users. Obtaining a permit can require numerous requests from service providers before approval is received. Once obtained, service users may need a volunteer or staff member to escort them, creating further hurdles for accessing healthcare services outside the camp. Once Rohingya PoCs exit the camps, services can be limited. Turkey provided registered refugees access to national health services.[8] However, refugees who are not yet registered where they are living, have limited access. Unregistered migrants do not access national health care services (other than emergency rooms). Many refugees and undocumented migrants depend on obtaining mental health services and care from IOs and NGOs.

As seen in the case studies, countries vary in how well integrated refugees are into national health care systems. Similarly, another gap in service can arise when national health services understand MHPSS differently from IOs and NGOs. Given budget constraints, governments generally prioritize limited forms of care. One IO HQ-level manager in Geneva explained:

[8] Syrian refugees are under group ”temporary protected status,” which provides immediate benefits but may be revoked, while other refugee populations are under ”international protected status,” which is not immediate. Refugees in Turkey are registered in specific locations within the country and cannot access benefits if they move to a location where they are not registered.

One of our partners did tremendous work in Ethiopia to help victims process trauma and teach resilience, but they would run into problems with Ethiopian government officials because they would only consider mental health as things like treatment for schizophrenia.

As a result, governments sometimes resist the interlapping, holistic support of MHPSS care, which they may not have the capacity or see a reason to take on. Additionally, mental health services are sometimes not integrated into emergency or primary health care (PHC) and/or are deprioritized in national curricula for medical training. As an example, Bangladesh has few qualified psychiatrists and clinical psychologists. According to one IO staff member, those who are qualified on paper may not be well trained. IO and NGO staff in Bangladesh reported that recruiting qualified staff was difficult. Few clinical psychologists or psychiatrists work in Cox's Bazar, they may not speak the same language as the Rohingya refugees and host communities, and those who cover this region rarely visited the camps or local communities.

In Turkey, there are more qualified professionals, but still not enough to handle the volume of cases, particularly as psychiatrists and psychologists leave the country in search of better working conditions. IO and NGO staff in Turkey noted that government doctors often have only 15 minutes to see patients, and therefore "in Turkey, the psychiatrists tend to just prescribe medicine, but medicine does not respond to all needs" (IO frontline staff member in Turkey).

In both countries, the lack of high-quality services for acute needs limited referral options for service users. Furthermore, NGO service providers in both countries reported a shortage of psychiatric hospital beds available to service users, indicating a potential break in the referral pathways for patients with acute needs. The shortage of MHPSS professionals also meant that service users have little choice in providers. This created a challenge for some female service users, who reported that they did not want (or were not allowed) to receive services from male service providers but were willing to receive services from women.

PRM-funded programs in both countries aimed to fill these service gaps to improve access to care for their service users. As noted earlier, in Turkey, service users with access to NGO services preferred the NGOs to government services, while in Bangladesh IO respondents

observed that the presence of NGOs improved the coverage of nurses in Cox's Bazar relative to other areas in Bangladesh. While important, IPs in both countries reported that given the scale of the problem being addressed, the existing services were not enough.

PRM-funded IPs tried to address shortages in specialized staffing using Mental Health Gap Action Programme (mhGAP) instruments and tools for training PHC doctors and nurses to recognize mental conditions and treat or refer clients, as necessary.[9] This training and subsequent supervision need to be done by qualified MHPSS clinicians. Participants who addressed mhGAP reported that it is effective, cost-effective, and scalable. However, as one clinician observed, Bangladesh had limited numbers of people qualified to provide mhGAP training and supervision.

Even among PRM-funded grantees with qualified staff members, many service providers reported that they need further training (e.g., drama and art therapy, CBT, and supervisory skills), to provide their services more effectively. Some reported that the training they received has not been effective. One frontline staff member in Turkey observed, "I've received three trainings in six years. In the mandatory trainings, we skip the videos, honestly, because we need a structured facilitator." A lack of trained providers also led to a dearth of qualified supervisors, since there were neither sufficient internal nor external staff who could provide supervision. Service providers observed that this lack of supervision reduced the program quality when frontline workers take on too many difficult cases. The lack of supervision may also increase provider insecurity, burnout, and overburdening.

Beyond staffing, IO staff in Geneva and Brussels reported that language barriers between patients and service providers were a challenge in MHPSS service delivery. In Turkey, IOs and NGOs responded by providing translation support and language classes so that patients could access treatment from Turkish doctors. Service providers found that "the service quality is very

[9] The most widely used are the Intervention Guide and the briefer and more tailored Humanitarian Intervention Guide

different when there is an interpreter. … An interpreter can help them express themselves and talk about what they want to talk about" (NGO staff member in Turkey), while some service users would not go to services without a translator. However, NGO interpreters were not always available and translators in public hospitals, not always reliable and sometimes asked for money. Furthermore, non-Arabic speaking service users had fewer translators available.

In place of translators, some PRM-funded programs responded to the language barriers by providing services in service users' languages. In Bangladesh, PRM-funded grantees trained community para-counselor volunteers to provide basic services and also created a mental health glossary in Rohingya. In Turkey, PRM-funded programs with Arabic-speaking medical specialists could provide specialized services. These standalone services had the potential to provide relevant services due to highly trained staff who spoke the same language as their patients. Service users said that there should be more such programs, as many people could benefit from them. Some travelled far to access these services. While effective, such programming did not reach non-Arabic-speaking service users. Furthermore, it is difficult to implement such an intervention at scale because operating a medical facility in Turkey (or in any country) requires that the doctors be registered to practice there. Since refugee doctors cannot quickly be recertified in the Turkish system, some qualified doctors then had to make referrals and act as translators. Some organizations have been working on training the next generation of Arabic-speaking service providers within the Turkish system.

The above challenges affect all MHPSS services. However, the largest service gap is at the level of clinical service provision, and there remains a smaller gap for non-specialized person-to-person services. The IOs and NGOs cannot usually offer these services and national health staff may also be stretched beyond capacity. While both service providers and users themselves prefer to receive community and primary health care support, access to clinical care and follow up for mental conditions (and often in the users' language) is lacking for those who may need ongoing support from a psychiatrist, clinical psychologist, and/or psychiatric nurse.

Several populations faced MHPSS service gaps. Persons with disabilities (PwDs), people on the move, rural people, older people, and men, may have had services available, but the services did not fully meet their needs or reach all population members. Other groups, such as LGBTQI+, do not always have access to services targeted to their specific needs, though they may access services that are not targeted to their needs.

In addition to the general service gaps described above, some populations faced particular service gaps and access challenges. For example, IO and NGO staff described services for PwDs in both countries and PwDs themselves appreciated the access to services. However, the respondents also noted gaps, particularly in terms of whether PwDs could access services in the face of stigma that led families to hide disabled family members, particularly girls with disabilities. Furthermore, most service providers described MHPSS support for people with physical disabilities, potentially indicating a gap for other disabilities.

Other groups that theoretically have access to services that they cannot always use are people on the move, rural people, the undocumented, and men. PRM-funded programs tried to address these gaps. In Turkey, some male service users, including men with disabilities, non-Syrian men, and men outside of big cities, reported that the services provided by PRM-funded activities were the only ones to help them. However, the need was larger than what these programs could provide. In Turkey, mobile teams serving rural areas and populations who travelled for agricultural work reported that there were few referrals made and not enough mobile teams. Furthermore, they could not so easily provide individual services as they did not have enough private, confidential locations to provide one-on-one services.

The team did not meet with older service users, but few programs were cited for older service users' specific MHPSS needs in Turkey or Bangladesh. Support for older individuals, who may be less mobile and face age-based discrimination, may be lacking.

Similarly, the evaluation team did not meet with individuals who openly identified as LGBTQI+. In both countries, service providers noted that LGBTQI+ people face serious discrimination.

Attending sessions that address their needs risked outing them and putting them in danger. IO frontline staff in Turkey refrained from discussing these issues openly for fear of alienating other participants and thereby losing chances to offer services to LGBTQI+ at all. Although not reported or observed during data collection, a reviewer of this evaluation noted an IO in Bangladesh is working through its partners specifically to support this community.

Those suffering substance abuse also had limited access to services. In Turkey, government facilities only serve Turkish speakers (or those with translators). Many PRM-funded organizations reported that they did not have the capacity to address these services. In Bangladesh, rehabilitation clinics had also closed for lack of funding.

IO staff members identified several challenges to tracking cost effectiveness. The extent to which organizations evaluate the cost-effectiveness of their interventions is limited.

When asked about costing interventions, IO staff members observed that many interventions are lifesaving but require long-term follow-up, and so are difficult to cost. Interventions at lower tiers of the pyramid reached a lot of people indirectly, making it hard to assess the full benefit. Some observed that MHPSS interventions are relatively low cost, with the main cost being human resources, with some higher costs due to training and hiring specialists and certain psychotropic medicines.

> *We do not look at what techniques are most cost-effective, but instead match [the] needs of [the] population. Make decisions that match symptom profiles. MHPSS is a low-cost service—we don't have expensive equipment or facilities—the costs are HR and training. We are a low-cost/high-impact service. – IO HQ manager in Geneva*

Others said that it was important to track costs but that it was difficult because cross-cutting MHPSS sectoral programs are embedded in existing financial categories. One IO manager in Geneva noted, "I am trying to understand finances but lack a tracking code."

U.S. Government (USG), IO, and NGO staff in the case study countries all noted that shifting priorities and the resulting program close out have caused harm when other services are not readily available to receive people who continued to need these services.

In Turkey, a European Civil Protection and Humanitarian Aid Operations (ECHO) program supporting MHPSS ended before the government was ready to take on these services. Service providers said this closure affected USG programming as they had assumed continued ECHO support. One Turkish NGO observed that the majority of service recipients (around 80 percent) then went to other NGO-run health centers, not state hospitals. The increased demand overwhelmed the remaining centers. In the case of PRM program close-out, NGO respondents reported that there is limited time to plan and transition patients. Another NGO reported that when funding ends, they lose trained staff members, exacerbating staffing challenges.

IO and NGO staff in Bangladesh and Turkey observed that funding for protracted crises decreased, with little evidence of development actors stepping in as the humanitarian community had to address new emergencies. IO HQ staff in Bangladesh reported that the situation is "a crisis, and maybe a bit of a silent crisis but it's still a crisis." Organizations were closing services, and those remaining had not yet been able to fill this gap.

Ultimately, program close out without a carefully planned handover strategy can cause harm by starting treatment without finishing it. As a service user explained:

> *After continuing this service for a few months or maybe some years, they just wrap up their activities, wrap up their program, close their program and they shut down. With these things, what happened, so she's saying that then we forget everything. What we learn from that activity, from that organization and from that person, we started forgetting. We start forgetting. – Female service user in Bangladesh*

EQ1: Conclusions

- PRM-funded IO and NGO programs respond to MHPSS needs ranging from integrating MHPSS interventions into basic services to offering clinical services by mental health specialists. Most MHPSS services focused on integration into basic services, strengthening community and family supports, and, to a lesser extent, on focused, person-to-person non-specialized support. PRM-funded programs provide limited clinical services beyond referrals. Service users benefit from both standalone and integrated programs. [EQ 1a, 1b, 1c]

- Due to the challenges of integrating with existing health care systems in low resource settings, the limited number of MHPSS professionals and supervisors relative to the demand, and the broad range of mental health challenges that service users face (further driven by limited access to basic needs and education), there are mental health gaps, particularly for person-to-person services, both clinical and non-clinical, that PRM-funded programs could not fully address, despite efforts to support focused person-to-person non-specialized and clinical care. [EQ 1a, 1d]

- Overall, PRM's approach to MHPSS service provision appears to work well for those service users who programs can reach. Referral pathways for clinical services (both inside and outside of camps) need to be strengthened in coordination with other MHPSS partners and primary health centers. To increase existing programs' impact and improve access to clinical services by mental health specialists, the number and capacity of qualified MHPSS professionals, both medical and non-medical, needs to be increased. [EQ 1d, 1e]

EQ1: Recommendations

- **To address staffing shortages, PRM should prioritize programs that build the capacity and skills of MHPSS professionals, particularly those who can train staff and community members to refer those with MHPSS needs to PHCs. Many PHC clinical**

staff in turn need further training to provide clinical services or referrals to higher level services. Programming could encourage relicensing and training new MHPSS professionals from the service user population so that they can practice in their new countries and reduce staffing shortages. To the extent possible, PRM should encourage NGOs to support a diverse range of practitioners and volunteers. [EQ 1d]. Frontline staff members providing MHPSS services require further training in order to strengthen their ability to provide services. Furthermore, IO and NGO staff members recognize the limited MHPSS capacity in local health care systems. With access to more trained staff, IOs and NGOs will be able to address staff shortages and supervision. As such, PRM should support grantees who are able to facilitate and training for a range of volunteers and professionals, including psychiatrists, psychologists, mental health nurses and social workers who specialize in MHPSS, to address the human resources gaps.

- **Over the next several years, PRM should engage in targeted advocacy with host governments to facilitate service users' entry into the labor market (and children's entry into education) to reduce stressors that drive MHPSS concerns. [EQ 1d].** Livelihoods remain a major driver for service users' MHPSS concerns. Host government regulations often hinder or prohibit PoCs' entry into the labor market, regardless of their skills and expertise. PRM advocacy to address livelihood barriers could increase the efficacy and relevance of existing MHPSS programming.

- **PRM should require their grantees to develop explicit, rapid close out strategies and plans (e.g., training and transferring services to local providers and communities) to ensure sustainability and continuity of services for service users and fund short term implementation of these strategies when grants are not renewed. [EQ 1d].** PRM should encourage service providers to develop explicit plans for how services will be sustained for users when funding ends and fund implementation of those plans in order to ensure continuity of care.

EQ2: Accountability to Affected Populations

Evaluation Question: How have PRM partners integrated the needs and perceptions of beneficiaries of PRM-funded programs into the planning, development, and evaluation of MHPSS programming?

The findings below address how beneficiaries are consulted in the design of MHPSS interventions and offered the opportunity to provide feedback on assistance; whether programming is adapted accordingly; and how program managers ensured that feedback reflects the full diversity of the populations served.

EQ2: Findings

Reported feedback mechanisms in Turkey and Bangladesh consisted of hotlines, complaint boxes, and direct feedback, both in individual and group settings. Service users reported that having multiple feedback mechanisms allowed for confidential and sensitive feedback.

Feedback mechanisms related to program logistics and programming content took place through a variety of methods as reported by service users in Turkey (more women than men) as well as IOs and NGOs in Turkey and Bangladesh. Feedback was reported through hotlines, complaint boxes, and directly from service users to providers. Feedback on program content was commonly reported to be captured through FGDs during meetings and surveys.

Respondents observed that multiple mechanisms allowed service users to provide different types of feedback through appropriate channels. For example, sensitive feedback could be most easily shared through confidential formats, whereas anonymity was not critical for feedback on scheduling. Table 3 provides an overview of the most frequently cited feedback mechanisms and which groups report using each mechanism.

Table 3: Feedback Mechanisms Reported by Respondent Group and Location

Feedback Mechanism	Surveys/Questionnaires (includes pre/post evaluations)	Focus Group Discussions	Hotlines/Phone	Complaint Box	Direct Feedback
Bangladesh	IO, NGO	IO, NGO	IO, NGO, Service user (F)	IO, NGO	IO, NGO
Turkey	IO, NGO, Service user (M, mixed)	IO, NGO, Service user (F, M)	IO, NGO, Service user (F, M)	IO, NGO, Service user (F, M)	NGO, Service user (F)

IO and NGO staff mentioned complaint boxes more often than service users. The range of respondents who discussed using other mechanisms was more balanced. While service users reported complaint boxes as a feedback mechanism, they did not provide detail around their application or why they might choose to use them or not.

PRM-funded NGOs reported that surveys and interviews, suggestion boxes, and local community representatives' meetings were the most common mechanisms prior to the COVID-19 pandemic. Due to the need to practice social distancing, the use of hotlines, WhatsApp messaging, and online platforms became important during the pandemic, whereas surveys and interviews less so. Suggestion boxes and local community representatives' meetings declined. Hotlines and direct feedback are reported consistently across IO, NGO, and service user interviews. Exhibit 28 in Annex 9 provides the full summary of the data.

> *NGO staff in Bangladesh responded to the interviewer on the most effective feedback mechanism, "Actually, it depends on the feedback types. If it's issues about the environment services…it comes from the verbal. If it comes to the staff behavior…we have a dedicated mobile number that we are providing for that." —NGO, Bangladesh*

IOs and NGO reported that feedback mechanisms are accessible for children and in formats reducing language and literacy obstacles for service users. Service

users and NGOs indicated that mechanisms are offered in confidential and anonymous formats, which encourage open feedback.

Ensuring that service users understand and feel safe when providing potentially sensitive information is central to collecting feedback that reflects service users' experiences. Some IOs and NGOs in Bangladesh pointed to emojis as a way to remove literacy barriers among young or nonliterate service users. IOs in Turkey and Bangladesh, and a Turkish NGO, reported using user-friendly mood scales. Such mechanisms allow children and service users with limited literacy skills to provide feedback. Several implementers designed mechanisms so that service users could provide feedback in their own language to reduce language barriers. IOs and NGOs in Bangladesh gathered feedback door-to-door and from community leaders.

NGOs in Turkey and Bangladesh and Turkish service users discussed the importance of being able to provide confidential and anonymous feedback. Feedback on MHPSS programming content can inherently be sensitive and personal. Providing safe formats gained service users' trust so they would be willing to share feedback.

> *The staff make us comfortable to share everything with them. They also ask us if we have any feedback, and they are very nice. —Female beneficiary, Turkey*

Program content was adapted or developed to respond to service user needs (e.g., programs for language skills, livelihoods, and sessions on S/GBV, family dialogue, and depression), which were identified through feedback mechanisms. Logistical adaptations (e.g., in scheduling, location, and materials provision), were addressed to reduce barriers to service user participation.

IOs, NGOs, and service users in Turkey, and NGOs in Bangladesh, indicated that program logistics and content were adapted to meet the service users' needs and enable their participation in programming. Respondents provided several examples of how their feedback led to positive and substantive programming changes. They shared relatively few stories where

feedback was not integrated. This may be because there are few negative stories or because of a response bias where they did not want to portray services as unresponsive.

Program logistics were adapted in direct response to service users' feedback, increasing ease and likelihood of participation as cited by service users and NGOs in Turkey. For example, NGOs shifted the timing of sessions and provided flexible scheduling to fit the service users' daily lives. They changed locations where services were offered to be more convenient and provided transportation stipends. They developed materials to the service users' needs (e.g., designing or adapting materials for illiterate or low-literacy skills). In Bangladesh, in response to service user feedback on the burden of walking many kilometers to see a psychiatrist, an IO arranged for a psychiatrist to come to the camp to see service users, removing the travel burden.

Beyond logistics, program content was also shaped to address service users' needs. Program adjustments were noted by all respondents (service users, NGOs, and IOs). A male beneficiary in Turkey indicated that the organization solicited input into activity creation and selection so PoC could select programming that fit their needs and interests and would help them to solve their problems. Other service users in Turkey reported that content had been introduced to teach local language skills (also cited by Turkish IOs) and that adjustments were made to increase the number of sessions presented on depression as requested by a group of service users. Service users were satisfied at being able to choose from various program options. As one reported:

> *Before beginning a new program, the staff would meet with us and ask individually what we would like to participate in. For example, they would give us multiple choices to pick from things we are interested in. After we all agree on something, they would propose it to the team leader, and then we would do the program we wanted. —Male beneficiary, Turkey*

An NGO in Bangladesh reported increasing awareness of gender balance in programming based on service user feedback. IOs and NGOs in both Turkey and Bangladesh cited that programming had been adapted to address the needs of PwDs. NGOs and IOs in Turkey reported the use of needs assessments, goal setting and tracking, and continuous evaluation among other

mechanisms to inform adaptations. NGOs in Turkey indicated that content adaptations included offering livelihoods programming and services for pre-school children.

IO respondents in Bangladesh provided specific examples of program content adapted or initiated based on service user needs. The examples included the Cultural Memory Center (to address service users' loss of cultural identity and heritage), the incorporation of religious songs and terminology; religious leader support for programming to reduce stigma, and sessions designed around S/GBV and family dialogue when these issues emerged in the community.

A small number of NGOs in Turkey indicated that program adjustments (e.g., introducing hygiene kits, psychosocial support (PSS) kits, free psychotropic medications, and transportation subsidies) were made in response to service user needs. Such adaptations were enabled by PRM's funding flexibility.

> *There are also FGDs and questionnaires at the end of the year to get beneficiary feedback. And, based on that the outcomes are used in the next year's proposals. —NGO, Turkey*

While respondents provided positive examples of involving service users' feedback in decision-making, service users reported persistent gaps in information in order to make connections to other service organizations and barriers to services including shortages of same-gender staff.

While these positive examples of adaptations of programming logistics and content were encouraging, gaps in information and referrals to services persisted as obstacles for addressing service users' needs. Service users in Turkey and an NGO in Bangladesh reported the need for clearer connections for migrants between service organizations to clarify the referrals process and to access information regarding services. For example, a woman beneficiary in Turkey requested a female psychologist to conduct sessions with her daughter. When this request could not be fulfilled, the service user decided to stop the treatment. A Bangladesh NGO described the difficulties a service user encountered in accessing assistive devices. Ultimately,

the service user obtained the device, but experienced lengthy delays. A male beneficiary in Turkey reported that:

> *I think connections—I need connections between organizations and migrants in general. …We need help in general—to be in touch.*

Though relatively few respondents mentioned the need for connections between organizations in order to help address their feedback, it is important to consider the need for clear and easy connections between service users and providers to address feedback and needs.

EQ2: Conclusions

The current feedback systems used by IOs and NGOs capture service user input and are generally effective at incorporating service user feedback to design and implement MHPSS programming relevant to the service users' needs. However, IOs and NGOs are aware of populations who face gaps in accessing services and whose needs are not then addressed in programming approaches. The data provide strong evidence that service users have access to a variety of feedback mechanisms. The mechanisms are appropriate for gathering information on sensitive topics as well as accessible for service users of various ages and literacy skills. [EQ 2a] In response to feedback, service users report that programs were adapted to ease logistical barriers and to tailor programming to address MHPSS needs. The data indicate that while organizations incorporate beneficiary feedback, more could be done to reduce information gaps to connect users to other services.

EQ3: COVID-19 Impacts and Adaptations

Evaluation Question: How has the COVID-19 pandemic affected the efficacy of MHPSS programming from PRM partners (both standalone and integrated)?

Findings below focus on how IPs adapted to the pandemic to maintain MHPSS programming and how IPs' understanding of best practices changed due to the pandemic.

EQ3: Findings

The COVID-19 pandemic increased the mental health burdens of service users and providers. Women and children are reported as facing specific vulnerabilities from IPV and S/GBV, social isolation, and lack of access to education.

According to responses from the survey, 71 percent of respondents (n=20) observed an increase in MHPSS caseload during the pandemic and 47 percent reported an increase of 20 percent or more. IOs, NGOs, and beneficiaries in Turkey and Bangladesh also reported that the pandemic increased the burden on service users' mental health. It is consistent with global data that in both contexts, interviewees highlighted feelings of isolation caused by lockdowns and loss of social networks as key reasons for the increased distress.[p]

> *We felt like life stopped when that happened. Everybody was sitting at home. My husband, stayed at home for a year. The kids got affected mental health-wise. So, it was very hard on them; they felt like this was the end, that's it. —Female Service User in Turkey*

In Bangladesh, isolation centers for those exposed to COVID-19 created fears and anxiety about potential forcible relocation to the Bashan Char Island, therefore, communities were reluctant to use these services. Respondents in Turkey and Bangladesh feared loss of resources (e.g., food rations and camp services) and livelihoods. Male respondents in Turkey reported that the economic impacts of the pandemic increased tensions in households, and both men and women reported increased financial insecurity. IO and NGO staff observed an increase in drug and alcohol abuse as a result of financial stress and a rise in substance abuse among youth.

Overall, interviewees believed children and women were disproportionately affected by COVID-19. Many IP staff in both countries stated that social isolation had the greatest impact on children. In Bangladesh, these effects were amplified by the lack of virtual schooling when education centers and children's play areas were closed. While schools in Turkey offered virtual classes, service users faced barriers, including unreliable internet connection and not having enough computers or tablets for each child. An IO staff member in Turkey said that sons were

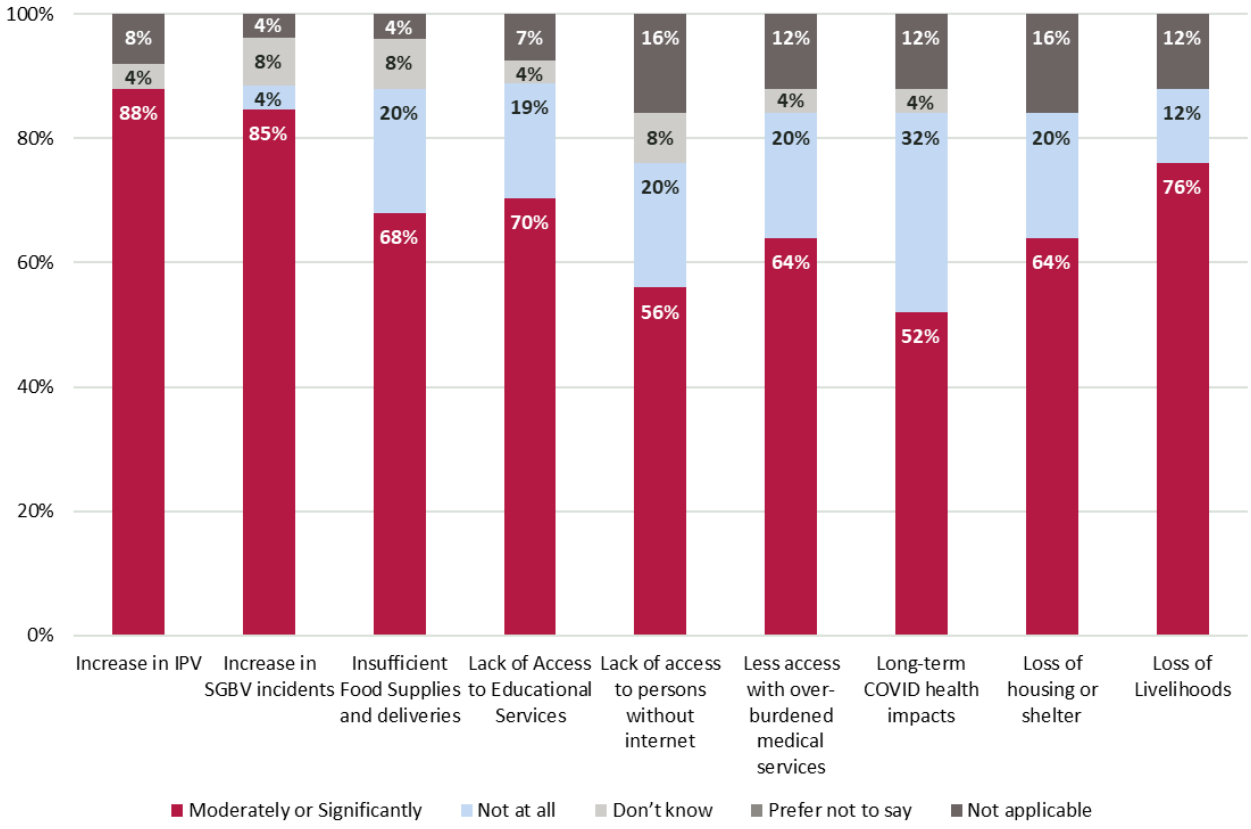
given preference to use laptops and tablets over daughters. In Turkey, staff said that the connection between children not being able to attend school and the worsening economic situation had led to an increase in child labor and child marriages. Additionally, HQ staff and service providers in both countries reported an increase in domestic violence during the pandemic. One staff member in Turkey stated, "there was a lot of domestic violence between the partners, and also, violence toward their children." Children were negatively affected by all forms of violence and insecurity in households. Staff in both countries stated that women and girls experienced an increase in S/GBV and IPV during the lockdown. Some connected the increase to economic stress while others to the suspension of protection services.

PRM's flexible funding allowed organizations to adapt to the COVID-19 pandemic.

IO and NGO staff in Turkey and Bangladesh appreciated that PRM's flexible funding mechanism allowed them to tailor MHPSS programming to service users' evolving needs. During the COVID-19 pandemic, government restrictions on MHPSS programming forced service providers to adapt quickly to virtual service provision, increase cash assistance and emergency programming, and integrate MHPSS messaging into health and protection sectors. Survey responses reflected in Exhibit 2 show that most NGOs shifted MHPSS programming resources and attention to respond to multiple issues during the pandemic,[10] such as: IPV (88 percent), S/GBV (85 percent), loss of livelihoods (76 percent), lack of access to educational services (70 percent), insufficient food supplies and deliveries (68 percent), loss of housing or shelter (64 percent), less access due to over-burdened medical services (64 percent), lack of access to the Internet/digital divide (56 percent), and long-term COVID-19 health impacts (52 percent).

[10] Related resource: Emerging Practices: Mental Health and Psychosocial Support in Refugee Operations During the COVID-19 Pandemic [https://www.unhcr.org/publications/brochures/5ee2409b4/mental-health-and-psychosocial-support.html]

Exhibit 2: The extent to which NGOs shifted MHPSS programming resources and attention to respond to the pandemic (n=25)



[Data table for Exhibit 2]

As an example of these adaptations, service providers in Turkey supplied Internet packages to address the digital divide and developed a tablet-borrowing system that allowed children to attend online classes and access entertainment. Also targeting children, an IO in Turkey produced and distributed children's books to address the MHPSS effects of the pandemic on children. A female beneficiary said she received a market card at the start of the pandemic, which alleviated some economic anxiety for her family. However, she feared that the program had ended. A service provider observed that PRM's support for cash assistance and basic needs programs required that, "we need to understand why the donor is withdrawing funding, just to understand why the donor is withdrawing funding if the need exists."

The pandemic has returned us to a time like at the beginning of the Syrian crisis. We have turned to the basic needs since people lost their livelihoods, this affected their well-being. — Turkey NGO staff

Adaptations to the COVID-19 pandemic included training of service providers from the local population, virtual service provision and supervision, further integrated services, and an increased focus on livelihood and food programming. Adaptations varied by country and target population.

In both Turkey and Bangladesh, beneficiaries and staff described hotlines and telehealth as a means of continuing MHPSS services during lockdown. Service users described these options as convenient and accessible. In Turkey, service users were able to access services through their own phones. However, in Bangladesh, Rohingya living in camps had limited ability to obtain SIM cards and access mobile networks. To manage this challenge, volunteers travelled door-to-door with a phone to connect service users to tele-counselling. Volunteers also provided para-counseling and health messaging related to COVID-19 and its potential MHPSS impacts. Service users reported learning breathing techniques and how to access services if they are needed in the future. Because homes did not necessarily allow for privacy during lockdown, these services were typically given to entire families at once as opposed to individuals.

In Turkey, staff and service users reported that barriers to digital services were the lack of access to devices and the cost of internet/data. The economic impacts of the pandemic and increased need for Internet and Internet-enabled devices created financial barriers. IOs and NGOs responded to these challenges by providing for basic needs through cash and material assistance (e.g., market cards and food baskets) and internet services (e.g., Internet vouchers and tablets for temporary use).

Individual telehealth services and virtual group activities were offered. Many organizations were able to deliver materials to group participants' homes, which could be used for remote activities and facilitated brief face-to-face contact to check on clients' well-being. Regarding the effectiveness of these remote activities, one staff member reflected that woman tended to

enjoy discussion-based groups, but men and children both responded best to activity-based groups which incorporated an MHPSS component. Social media played a key role in maintaining connection in Turkey during lockdowns. Service users and staff both mentioned using Facebook and WhatsApp as platforms to interact with one another and to maintain social networks during isolation. The return to in-person services caused some concern for service users. In Bangladesh and Turkey, respondents described a hesitation to return to service centers due to fear of contracting COVID-19. However, they also reported that centers took proper precautions using masks and social distancing.

Survey findings showed that 29 percent (n=13) of respondents moved to fully remote work while 49 percent (n=22) moved to partially remote work. Most provided extra training to staff to address pandemic-related issues, vaccines and/or personal protective equipment (PPE), staff counselling, and maintained salary and hours to maintain staff employment. Some (n=17) increased leave/sick benefits. When asked to describe what approaches their organization took to strengthen MHPSS response systems in their countries as a result of the pandemic, 36 percent (n=9) of respondents described introducing virtual service provision, 24 percent (n=6) described expanded staff training, and 20 percent (n=5) described integrating MHPSS components into direct COVID-19 responses.

Virtual service provision provides wide reach and flexibility, especially for women and PwDs who may not be able to leave their home to receive services. However, it requires access to digital devices and risks not reaching people experiencing domestic violence and S/GBV.

Virtual service provision was the most common adaptation during early pandemic lockdowns mentioned in both interviews and survey. In Turkey and Bangladesh, interviewees observed that service users and providers grew more comfortable with tele-counselling services over time. Despite many Rohingya's limited access to mobile networks, service providers in Bangladesh used tele-counselling to continue services during lockdown. Volunteers traveled door-to-door with phones to use for these sessions, however the lack of privacy in the home meant sessions were for family not individual counselling, which made it more difficult to

address domestic violence. In Turkey, service providers also reported that people experiencing domestic violence, IPV, and S/GBV were trapped in their homes with their abusers during lockdowns and when violence was on the rise. Both virtual and in-person protection and MHPSS services were minimally available to the survivors and experiencers at this time, putting them at a greater disadvantage. Service providers explained that most homes lacked the privacy needed for a person to safely contact protection or MHPSS services away from their abuser. On this barrier, one respondent said:

> *During COVID-19, we tried to support the survivors through the phone. It is also difficult because for the survivor it is harmful and also furthers harm they can face in the house because of the perpetrator always available in the house. That's why we cannot, we did not support. —Bangladesh NGO*

Despite these concerns, tele-counseling and virtual service provision were popular among service users. One woman in Turkey reported receiving services during lockdown while living in another city and she appreciated that flexibility. Services became available virtually throughout the country. In a group discussion in Turkey, women who received services debated whether in-person services or virtual services were preferable. Some felt that virtual services were the best option because their responsibilities at home were too great to allow them to travel to the center, while others found the home to be a distracting environment and preferred center-based activities. Staff were mixed and several suggested hybrid services as the best solution. One IO staff member noted that the importance of maintaining face-to-face services in working with mobile populations in the country who could not be reached virtually.

Implementers integrated MHPSS services into health services during the pandemic in order to respond to MHPSS needs including those pre-existing, amplified and/or driven by the pandemic.

During lockdowns when national governments allowed only select services deemed “essential” to continue uninterrupted, implementers adapted by integrating non-clinical MHPSS service provision further into other services. Many incorporated lower pyramid level MHPSS

components in COVID-19 response activities by addressing the impacts of isolation. In Turkey, one IO traveled door-to-door visiting service users and delivering COVID-19 hygiene kits. These home visits allowed staff to identify cases at "the ultimate risk" and provide case management, referral, and PSS. To provide MHPSS services for women experiencing IPV and GBV, an NGO in Bangladesh trained midwives in basic MHPSS service provision skills. Integrating into medical services through training service providers with tools like PM+ allowed services to continue but did increase the workload for medical service providers responding to COVID-19. IOs provided training packages for teachers in a virtual classroom to identify children with potential MHPSS needs, provide basic support, and link children to service providers. Many interviewees who shared their experiences integrating MHPSS services to adapt to COVID-19 went on to describe their preference for integrated MHPSS service delivery.

> *The problem is that the MHPSS is a cross-cutting issue. This program is implemented by the different sectors like health, protection, education. Those programs under the health or the MHPSS program are considered as essential actors, as in providing support from the psychosocial counselor or the health post. This [specialized] service was actually not affected by those restrictions, but the other service, which is implemented at a community level and also provided through protections, these are actually affected. —Bangladesh NGO staff*

As the burden on staff and service providers increased, additional support was needed, including training of more MHPSS service providers. Existing providers needed support to cope with loss and address their own stresses, secondary stress, and burnout.

IPs reported a range of burdens resulting from the pandemic including increased workloads, contracting COVID-19, care burdens for family and friends who contracted COVID-19, family member deaths, a need for online supervision, secondary stress/increased mental health needs, and burnout. A Bangladesh service provider said that health care staff experienced stigma during the pandemic as community members feared contact with them given their proximity to the virus.

Two main methods for addressing staff and service providers' needs were reported. The first was to increase health benefits and MHPSS resources dedicated to staff care. The second was to train more MHPSS service providers, to increase staff resources and supervision and decrease caseloads. In Bangladesh, Rohingya volunteers who were recruited and trained to provide PSS for service users living in the camps, reduced some of the burden on MHPSS staff.

EQ3: Conclusions

- The COVID-19 pandemic had positive and negative effects on MHPSS. While isolation increased MHPSS needs, the pandemic also led to more MHPSS conversations online and community-led support. Seeking services became more normalized and virtual service provision increased access to care for many. Some groups experienced increased needs and did not receive services in-person or virtually. Implementing staff and beneficiaries alike were most interested in hybrid services moving forward.
- The pandemic brought to light the needs of MHPSS service providers. Reports of burnout, high turnover, increased stress, and increased secondary stress demonstrated the need for more trained service providers and the importance of self-care interventions for service providers.

EQ3: Recommendations

- **Over the next funding cycle, PRM should work with its IPs to determine where and when hybrid approaches will and will not be feasible and advisable and work to develop these approaches. [EQ 3a, 3b]** Hybrid approaches are effective for many organizations but are not possible in all contexts. Studies may be needed to address the utility and relative effectiveness of different models.
- **PRM should ensure that future funding allows for ongoing self-care interventions for mental health professionals and volunteers. [EQ 3b]** When service providers are experiencing challenges, that can affect service users. Quality of work can be affected, and staff turnover is more likely, making programs less effective.

- **To minimize the impact of future global health events, health service providers should receive ongoing training on MHPSS service provision. [EQ 3b]** With more trained and accessible MHPSS service providers and volunteers, systems will be more resilient for the next challenge.

EQ4: PRM MHPSS Strategy

Evaluation Question: What changes or updates to PRM's MHPSS strategy would help strengthen PRM's ability to meet the MHPSS needs of its PoCs?

The findings below address to what extent PRM's existing health strategy informs funding decisions; the strategy is a foundation for future decisions, including post-COVID-19 efforts to build the humanitarian response back better, and the changes that may be needed to guide PRM policy and funding decisions.

PRM's fiscal year (FY) 2018–FY 2021 Health Strategy objectives were to:

- Advance existing health partnerships and seek new partners for health programming.
- Expand the integration of refugee populations into host government health care systems.
- Improve refugee access to mental health and psychosocial support services.
- Increase access to health care services for populations of particular concern, including women, children, and PWDs.[q]

EQ4: Findings

Including MHPSS in PRM's health strategy reinforced the understanding that addressing mental health is an intrinsic (sine qua non) part of humanitarian health care.

According to the U.N. Special Rapporteur on physical and mental health, 'there can be no health without mental health,' yet 'nowhere in the world does mental health enjoy parity with physical health in national policies and budgets or in medical education and practice.' The global neglect of mental health is perhaps most stark and severe among refugees and migrants."[r] During the C0VID-19 pandemic, governments and civil society increasingly recognized mental health as an essential part of health care provision. Many people were coping not only with the physical aspects of COVID-19 but also with anxiety, stress, and loss. An IO Geneva manager observed that while international awareness of the need for MHPSS increased and may have helped counter some of the stigma around seeking these services, that the initial increase in funding for MHPSS worldwide had levelled off by the fourth quarter of 2020. Despite an uptake in demand, public expenditures on mental health remained low, comprising a global median of 2.1 percent of government health care expenditures.[s]. For service users, treating MHPSS as part of the health sector proved to be critical for allowing service provision to continue not only online but also through community volunteers, PHCs, and hospitals during lockdowns. In Bangladesh, for example, treating MHPSS as part of emergency health services allowed these critical services to continue when lockdowns shut down other sectors. However, without the usual MHPSS services, IPs in Turkey, Geneva, and Belgium reported significant disruptions in services, medication, and follow-up support.

MHPSS service integration across humanitarian sectors was critical for obtaining access, identifying needs, providing PSS, and making referrals to PHC practitioners and if needed, to higher levels of care.

During 2018–2021, PRM's MHPSS support was not captured solely through its health strategy. Most IPs addressed MHPSS by integrating these services into other sectors and basic services (level one of the pyramid) and providing community-level programs to support service users' well-being (level two). As an IO staff member observed, "without the community element, then so many people would fall through the cracks and fall through the net and not be able to receive [the] services that they would if the community system is in place." Peer-to-peer counseling, adolescent support groups, and/or children's, caretaker's, and women's safe spaces were all cited as early-stage interventions and good prevention practice. When children were out of school during the lockdowns, restoring online education was critical to maintaining children's and caregivers' well-being. As one NGO manager observed, "there is a need to train adolescent girls and boys and address their lack of education opportunities, substance abuse, and community conflict. There needs to be parenting skills and positive parenting—an intervention with adolescent boys and girls since they are the most vulnerable. Especially disabled children or for some adolescents with intellectual disabilities, there is a need for student materials, tool kits, child-focused activities, etc." Several IPs (in all field sites) reported that their programs supporting basic needs (e.g., livelihoods) and strengthening social support systems helped to prevent mental health conditions and ensured community support for those suffering these conditions. One (IO) psychiatrist observed that addressing the lower levels of the IASC pyramid to meet basic needs and social support lessened the demand at each subsequent higher level.

In addition to health, service providers most often referenced the protection (including child protection and S/GBV), education, livelihoods, and nutrition sectors as critical to MHPSS integration and their sectoral operations. In face of

funding cuts, they were also concerned that MHPSS interventions could be deprioritized by sector specialists.

Ever since the IASC recommended integrating MHPSS across sectors, many IPs observe that has remained the primary strategy for accessing, addressing, and referring PoCs. They also reported that cross-sectoral integration remains an important strategy to counter cultural stigma and resistance to seeking services. Across field sites and as evidenced in the portfolio review, the IPs most often cite protection (including S/GBV and child protection), livelihoods, education, and nutrition sectors as the most relevant for cross-sectoral integration[t]. The Global Protection Cluster also argues for including MHPSS in case management and "that stronger engagement of protection actors with MHPSS strengthens the overall protection response." [u] In Bangladesh and South Sudan, nutrition workers, working with pregnant and lactating women, could identify and address postpartum depression and IPV. Livelihoods for wage earners and education for children were key to providing psychosocial support (and providing MHPSS support was critical to many people's capacity to engage in these activities). One IO further observed that Camp Coordination and Camp Management (CCCM) and another IO, that the WASH sectors benefitted from and/or contributed to MHPSS service integration and delivery. During fieldwork in Turkey, NGOs and an IO suggested that MHPSS service provision increased the effectiveness of not only their livelihoods programming but also protection and education services. As one IO advised, their online educational programming benefitted from providing simple coping strategies for youth. MHPSS expertise helped protection officers to identify refugees needing S/GBV services.

As several IPs observed, for their sectors to address MHPSS required training or additional MHPSS staff to support their work. IOs observed that the main weakness of cross-sectoral integration would be sustainability. In face of funding cutbacks, several IPs warned that these services would most likely be deprioritized by other sector specialists. Integration with community, local, and/or national actors, which may be necessary to sustain the services, is difficult when they, too, are often stretched to capacity.

Accountability to Affected Populations (AAP) was well documented by PRM's NGOs, and many IPs developed strategies to include PwDs. AAP measures led to partners developing new strategies for MHPSS provision (e.g., mobile clinics, online programming, and community volunteers).

Being accountable did not guarantee that partners were able to access the most affected and vulnerable service users, particularly during the pandemic. Some of the documented barriers were logistical (internet coverage and distances), service users' lack of legal status, and socio-cultural (stigma towards LGTBI+, religious, and familial statuses).

PRM's partners documented AAP through needs assessments, surveys, and focus groups, and through different channels (phone, internet, boxes, and face-to-face meetings). During the evaluation period, as evidenced in Bangladesh and Turkey, several IPs made extensive efforts to include persons with disabilities (PwDs) in their programming. Their assessments and work further documented who remained the most vulnerable and hardest to access. Those at risk included girls with disabilities, women and girls suffering from IPV, S/GBV, and/or forced early marriage, orphaned and unaccompanied children, LGBTQI+ individuals, older individuals, the undocumented, and displaced persons on the move (e.g., IDP agricultural workers).[11] Older people may have also been left out or difficult to access as they were rarely mentioned or included in the interviews.

To address their AAP findings, an IO introduced mobile clinics to reach geographically dispersed people. Many IPs trained community volunteers, who were often young, to access households and locally affected populations during lockdowns. They demonstrated capacity to reach out

[11] The most vulnerable were both evidenced in those who the NGOs and IOs had to go furthest to reach but also those who were not included in the interviews but clearly had documented needs (e.g., older people, LGBTQI, and S/GBV/IPV survivors).

directly in households to diverse groups of PoCs. However, as IOs observed, community volunteers and local service providers required ongoing training, support, and supervision. An IO Manager in Geneva reported,

> *Many iNGOs and UN agencies have done multiple specialized trainings, have brought specialists from other countries to train HR, but it is not sustainable, therefore there needs to be more research on sustainable modalities. [This IO] is now focused on conducting more TOTs so there are at least two people per organization with in-house capacity, and then we roll this out in communities so that community has sustainable resources, so that when one leaves, the knowledge remains. There is a need to work closely with communities with a bottom-up approach, and really working with refugees themselves to design the modalities and ask them what they want to do.*

PRM increased support to its IPs through multi-year funding and added new partnerships with national and local NGOs.

Developing effective MHPSS services that were culturally, nationally, and locally relevant required time. PRM's shift to multi-year funding provided a more realistic time frame for their IPs to develop and implement MHPSS interventions across diverse humanitarian contexts. As a PRM Refugee Coordinator observed, **"**For our program, continuation is very important. MHPSS interventions are not one-time interventions that can solve problems, there has to be continuation and follow-up. That's why we moved from two-year to three-year funding this year for the NGOs. Continuation is important for individuals and for programs." The Bureau's increased support for national and local NGOs/CBOs and PoC-led providers, a localization strategy, helped build new partnerships and capacity that may be more culturally relevant and

sustainable.[12] PRM's dual funding strategy for MHPSS, where 86 percent of funding is programmed through its IO implementing partners to meet all emergency and humanitarian priority needs, and 14 percent through NGOs designated specifically for MHPSS interventions, reached a range of IPs. Across all IPs, PRM supported interventions to address all levels of the pyramid of MHPSS provision.

PRM's MHPSS milestone, "increased engagement between PRM and WHO on MHPSS to enhance programming," was not realized during the programing period that was in scope for this evaluation (2018-2021). However, PRM continued to be perceived as a major donor in advancing MHPSS humanitarian programming, knowledge, and innovation. WHO and other IOs indicated that PRMs participation as an observer would be very welcome on MHPSS country level Technical Working Groups (TWGs) and at the global level MHPSS IASC Reference Group (RG), currently co-chaired by WHO and IFRC.

Given a USG policy during the evaluation period to cease funding to WHO, PRM lacked some of its usual opportunities to advocate for MHPSS in humanitarian operations and to collaborate effectively at global and national levels.[13] The appointment of two MHPSS USAID advisors and inter-agency coordination at the U.S. Mission in Geneva improved USG coordination with the IASC's MHPSS Reference Group from 2020 onwards. During interviews with WHO, they "expressed strong interest to engage with and support PRM regarding MHPSS programming."

During the evaluation period, the international MHPSS Reference Group, currently led by WHO and IFRC, developed a minimum service package (MSP) to develop a common consensus on

[12] Localization is certainly politically popular in a country, such as Turkey, but required training and an organized transfer of responsibilities from an INGO to the local NGO/CBO, which happened in some countries and not others. National NGOs/CBOs that did not share the PoC's language also needed to find ways to include PoCs in their programming.

[13] WHO/Turkey faced the brunt of the U.S. Government's decision not to fund WHO when the USG pulled the plug. For three months, KfW [German aid] stepped in and supplemented other projects in the Refugee Health Program. However, they had not allocated funds for this activity and had to phase out after the three months.

standards, protocols, and practices. The MSP is being trialed in five countries and online globally. National MHPSS Working Groups, in turn, are adapting the standards and protocols to be culturally nuanced and nationally relevant (as reported in Turkey and HQ interviews). IO Geneva managers observed that throughout this period PRM provided unique support to specialized NGOs/CBOs for MHPSS research, training, and implementation and could make a valuable contribution to the current discussions and coordination aimed at developing common standards through the MSP. They argued that in addition to USAID, PRM should also have observer status on the IASC's MHPSS RG and national, MHPSS Working Groups.

Implementing partners' monitoring and evaluation systems characteristically did not address outcomes (other than self-reported) [14] and impact data, which were reported to be difficult to obtain within limited time frames and pandemic lockdowns.

As evidenced in the portfolio review, the NGOs tracked program-specific outputs (e.g., numbers of participants in trainings) and two outcome measures (self-reported, satisfaction and well-being).[15] Since client/beneficiary satisfaction was universally reported at 95 percent or above, it is unclear how discerning this indicator was for measuring service user feedback (Inception Report). An encouraging trend in later NGO proposals was inclusion of outcome and impact indicators of service user functionality and well-being through a case management approach. In September 2021, the IASC published its Common M&E Framework for MHPSS in Emergency Settings, which are included in the MSP.[v] This most recent framework, addressing the "Six Core

[14] The two reported outcome measures are the "percentage of beneficiaries who report an improved sense of safety and well-being at the end of the program, disaggregated by age and gender" and "the percentage of people satisfied with mental health and psychosocial care they or their families receive." As evidenced from the portfolio review, these beneficiary satisfaction measures were not reported less than 95 percent so are not particularly useful.

[15] Annex 10 has the list of PRM standard indicators for NGOs.

Principles," provides five outcome domains, six goal impact indicators, and means of verification.[16] This Framework may help in guiding PRM's policy and funding decisions.

IPs, particularly for their cross-sectoral operations, lacked systems to track MHPSS expenditures and in general, there was little to no financial analysis of interventions and programming.

The IPs reported that costing MHPSS interventions was difficult because these data were not tracked or pulled out in cross-sectoral programs. For both standalone and cross-sectoral programming, many MHPSS interventions were also difficult to cost as they were long term. However, IO staff noted a newly developed MSP costing tool will allow for cost estimations of different MHPSS activities in selected humanitarian settings. Being able to make the financial case for MHPSS investments may be increasingly relevant in face of increased demands on the humanitarian system. One IO clinician observed, "if donors [are] looking to reach big numbers, MHPSS doesn't have big numbers. We don't have prevalence studies to go to scale. If humanitarian funding is being cut back, this service is most likely to be cut back first." The economic losses from MHPSS benefit-to-cost ratios told a different story.

In 2010, the global economic impact of MH disorders was $2.5 trillion with two-thirds from indirect costs due to productivity loss (World Bank 2018.:1). The same study found that investing in mental health yielded a benefit-to-cost ratio from 3.3 to 5.7 in low-income countries. Many MHPSS interventions in fragile, conflict and violence-affected situations are also reported to be cost-effective, as measured by cost per disability-adjusted life year (DALY)

[16] The Core Principles are to assure human rights and equity, participation of local affected populations, do no harm, building on available resources and capacities, integrating support systems (not standalone operations outside other systems), and multi-layer supports for MHPSS.

with a DALY less than three times GDP per capita and cost/DALY less than one times GDP/capita.[17]

There was a widespread perception of a tradeoff between addressing the severity and the magnitude of mental health needs.

Many IPs focused on including MHPSS support in basic services, strengthening community and family supports, and to a lesser extent, providing person-to-person, non-specialized support. Some question whether addressing severe mental health conditions through national health care systems, or providing specialized MHPSS services for POCs, would be too costly and difficult. However, as an IO clinician in Turkey observed, "a MH (mental health) disorder affects far more than the individual and a person with chronic conditions needs at least one adult to take care of the disabled person. Most of the mothers of those with schizophrenia and bipolar disorder are not in the labor markets."

WHO's Choice (2005) program found that the most efficient interventions for common mental disorders (depression and panic disorder) were very cost-effective (each DALY averted costs less than one year of average per capita income).[w] Community-based interventions for more severe mental disorders using older anti-psychotic and mood-stabilizing drugs were cost-effective (each DALY averted costs less than three times the average annual income). Although such studies needed to be replicated for specific contexts, the Choice findings suggested less of an economic tradeoff between addressing the severity versus the magnitude of MHPSS.

In face of limited national capacity, there may be an economic argument for continuing to support refugee and migrant health clinics and standalone programs to address severe mental health conditions. Over time, the provision of care, including for severe MH conditions, by

[17] World Bank (n.d.) FCV Health Knowledge Note. Mental Health and Psychosocial Support in Fragile, Conflict, and Violence (FCV) Situations.

trained and supervised non-specialist, PHC providers could make MH care more widely available to PoC populations and less costly and stigmatizing. [18]

Most IO and NGO programs, whether integrated across sectors or standalone programs, lacked sufficient MHPSS human resources and capacity to address the increased demands at all levels of the pyramid, particularly during the pandemic, where basic survival needs were not being met in some cases.

Despite programming to reach all levels of the pyramid, levels three and four remained under-resourced (IO and NGO interviews in Geneva, Brussels, and Turkey). As evidenced in Bangladesh and Turkey, coordinating referral pathways, case management procedures, and data sharing proved to be difficult and was not systematized. The WHO mhGAP training and uptake for PHC providers to recognize and address MH referrals had begun but lacked trainers and training of trainers to develop the human resources needed to go to scale and be sustained. During the pandemic, PRM and the IOs' strategy to integrate clinical psychological and mental health care into national health care systems suffered setbacks. National health care systems were over-stretched. With lockdowns and other health priorities, mhGAP training and supervision of PHC providers were curtailed. As evidenced in Bangladesh, there may never have been enough qualified trainers to implement this integration strategy. PRM's Refugee Coordinators and Program Officers, who could liaise with Ministries of Health and of Social Welfare, likewise had limited ability to address and support national integration during lockdowns.

IPs reported that national health care systems were under-resourced and challenged particularly during COVID-19. IPs reported that there was not enough medical training of clinical psychologists and psychiatrists, who in turn could train PHC providers to recognize and refer mental health conditions. Some

[18] Refer to: mhGAP Humanitarian Intervention Guide [https://www.who.int/publications/i/item/9789241548922]

countries had very few clinicians (e.g., one country had only one psychiatrist). Given the increased demands for mental health services in northern countries, health care migration of psychiatrists and other critical providers to those countries reportedly increased.

Global awareness of the need for MHPSS during COVID-19 initially led to increased government investment that is not likely to be sustained. According to one IO manager, in face of other economic pressures on health care systems, that initial increase had already levelled off. The Russian-Ukrainian war protracted and recurring conflicts, and natural disasters have led to new, increased demands on humanitarian funding. Thus, the PoCs' need for access to national health and social welfare systems intensified, due to both severe mental health conditions and basic needs.

Yet, significant barriers to PRM's second health strategy objective of accessing national systems remained. In the two case studies, those barriers were: limited government capacity and/or agreement to provide access; overly complicated, and at times non-functioning, referral systems; linguistic and cultural differences; geographic distance to services; pharmaceutical approaches to mental disorders without sufficient investigation, information on potential side effects, or concurrent counseling support; long waits, brief consultation times, and limited personnel and capacity; and cost and lack of access to national insurance schemes (particularly for undocumented and migratory workers). A lack of human resources to address demand remained by far the most critical issue for both the humanitarian community and national health care systems, particularly in low-income countries.

IPs cited human resource challenges that need to be addressed for the health strategy to realize its MHPSS objectives. During the pandemic, staff suffered burnout from long hours, their own losses and grief, which may have led to high rates of staff turnover. The online work placed increased demands on time and for organizing direct supervision. Health care migration, particularly of psychiatrists and clinical psychologists, to wealthier countries further strained resources for low and middle-income countries to address the increased demands on their health care systems. After eight years of medical training, a psychiatrist trained in Turkey could

earn far more in Western Europe, the UK, and the U.S. (reported by an IO). Many recent Turkish medical graduates reportedly left to complete residencies in the U.S. Not only were services constrained for PoCs, but locally affected populations faced the same barriers with limited referrals and access to higher level mental health services. As noted in the Inception Report, in countries with only a handful of psychiatrists and clinical psychologists, the integration strategy would increase pressures on already overburdened and severely under-resourced systems.

Implementing standard MHPSS practices, such as mhGAP training for PHC providers, assumed availability of trained practitioners. International training, provided by IOs, specialized MHPSS NGOs, and universities, addressed some of this need. However, as MHPSS is a rapidly evolving field, there remained a demand for new graduates and refresher/in-service training opportunities.[19] One university-based mental health program funded through an IO prior to 2018, for example, had created a robust professional network of providers, who continued to share experiences and knowledge across borders online throughout the pandemic.

In spite of their tragic nature, and notwithstanding the human suffering they create, emergency situations are also opportunities to build better mental health care" (WHO 2013:4). The opportunity and the necessity to implement WHO's "Build Back Better" remain equally relevant today.

In 2013, WHO's "Build Back Better" strategy recognized that mental health was crucial to the well-being, functioning, and resilience of individuals, societies, and countries recovering from emergencies.[20] In 2013, WHO also recognized the importance of sustaining these services.[x] In 2018, PRM's health strategy made its third health strategy objective to "improve refugee access

[19] One IO MHPSS manager, given the time and cost intensive training required for psychiatrists and clinical psychologists, recommends enlisting psychiatric nurses to address some of the service provider gaps.
[20] "Build Back Better" in this evaluation refers to the WHO's Building Back Better strategy, which argues that emergencies, despite their "tragic nature and adverse effects on mental health," create opportunities for mental health reform.

to mental health and psychosocial support services." During the pandemic, this objective became ever more important to meet an increasing demand. PRM's second health strategy objective of integration with national health systems offered a way to address the increased demand and go to scale through effective referrals and trained PHC providers. As a health strategy, the same sustainability of PSS for levels one and two through relevant national welfare/social services' ministries was not addressed.

In face of the barriers to integration, the national integration strategy at times seemed unlikely to be realized. There was limited evidence of uptake during the evaluation period. That said, a PRM Refugee Coordinator observed "in the context of Turkey, the fact that health care is provided for free is crucial. Not to everyone, there are restrictions here and there… What Turkey has done, given the scale of the refugee population to provide free education, free health care, is something to be commended. If that could be replicated, it should be."

Expecting under-resourced national health care systems to continue to provide free services may be highly optimistic and unsustainable without a greater international commitment to providing the resources and knowledge needed to support the expected interventions. As an IO manager observed, "Sustainability includes government support and donors need to realize that there are other ways to involve the government without directly giving the government money." The most valuable resource in this field may be trained MHPSS practitioners at all levels of service provision that the humanitarian sector requires and could provide. There is also a financial case for investing in MHPSS human resources, which became increasingly compelling during the last pandemic and in face of those to come. In 2022, investments in MHPSS may be ever more needed for building a global resilience to cope with protracted conflicts, epidemics and pandemics, and the increasing disruption and uprooting from natural disasters and climate change.

EQ4: Conclusions

- PRM's strategy addresses relevant concerns about the role of mental health in health care provision, but simply as a health strategy does not capture the Bureau's critical

cross-sectoral support, particularly related to protection, education, livelihoods, and nutrition. [EQ 4a]

- PRM has the experience, international reputation, and tiered- and multi-year funding modalities to advance the MHPSS agenda on international and national levels; to advocate, where possible, for PoC's inclusion in national health care and social welfare systems; and to strengthen donor coordination on the MHPSS technical working groups. [EQ 4b]

- AAP measures were most effective in encouraging new programming strategies. However, service users' experiences and requirements are best captured through locally and culturally adapted, outcome and impact measures that reflect IASC's (2021) "Common M&E Framework to implement the Core Principles of: Human rights and equity, Participation, Do no harm, Integrated services and supports, Building on available resources and capacities, and Multilayered supports. [EQ 4c]

- Monitoring and evaluation systems, lacking financial, outcome, and impact metrics, are insufficient for strategically allocating resources, making the case for the cost effectiveness of community-based interventions, and determining how to integrate with national health care systems and to go to scale most efficiently. [EQ 4c]

- Given a rapidly evolving field with reported high health care provider turnover and migration rates and language and cultural differences, and secondary stress, existing human resources—specifically trained mental health and PSS service providers—are insufficient to address the needs and expectations at every level of service provision across diverse populations and to go to scale through national integration. [EQ 4]

EQ4: Recommendations

- **PRM's MHPSS strategy would benefit from updates to reflect the Bureau's PSS community-based and cross-sectoral programming, COVID-19 adaptations, and expected funding modalities, outcomes, and impact. [EQ 4a, 4c].** PRM's COVID-19

response and recovery plan highlights specific sectors for integration of MHPSS work. PRM's health strategy revision would benefit from similar language and other updates to reflect current programming.

- **PRM Refugee Coordinators, Program Officers and its MHPSS Program Officer in Washington, D.C. should participate as observers on the international and national MHPSS Working Groups to supprort and coordinate with other donor, IO, and NGO/CBO strategies for rolling out the Minimum Service Package (MSP) and for integrating MH and clinical psychological services in national health care systems, and psychological and social support in national and community social welfare systems. [EQ 4b, 4c].** Participation in these working groups will facilitate coordination between donors and provide opportunities to both streamline reporting requirements across donors and to ensure complimentary efforts when funding different implementers.

- **PRM should encourage its NGOs, through its AAP requirements, to develop specific, local strategies for accessing the hardest to reach. [EQ 4].** Existing AAP systems are responsive to service users who are reached. The next step in improving accountability is to reach affected populations who currently have less access to services.

- **To the extent possible, PRM should encourage its IPs to organize monitoring and evaluation systems that address outcomes and impact with some basic cost and expenditure data, and to use the IASC M&E framework. [EQ 4c].** Monitoring and evaluation systems that focus on outcomes and impact, rather than outputs and client satisfaction, will help facilitate strategic resource allocation.

- **PRM should encourage its IPs to develop some simple benefit-cost analysis to assist in determining where best to target limited resources in a given population based on the PoC profiles, needs, infrastructure availability, and existing resources. [EQ 4c].** Systems that allow IOs and NGOs to capture cost can work in conjunction with outcome- and impact- focused monitoring and evaluation systems to facilitate strategic resource decisions.

- **PRM should prioritize support at all levels for IPs that address human resource requirements from training community-based volunteers to re-credentialing refugee psychiatrists and/or training for national and local psychiatrists, clinical psychologists, psychiatric nurses, and PHC clinicians in addressing humanitarian mental health needs. Strengthening the human resource base may be the most effective way of expanding the integration of refugee populations into host government health care and social welfare systems. [EQ 4b, 4c].** Human resource shortages are a barrier to providing quality care to PoCs who need MHPSS services. A key priority to address the needs of PoCs is to ensure there are a sufficient number of trained practitioners who can implement services at all levels of the IASC pyramid.

Alignment of MHPSS Initiatives to PRM's Functional Bureau Strategy

MHPSS programming is critical to PRM's mandate "to provide life-saving assistance and protection to the world's most vulnerable people."[y]

The objectives in this PPRC will support PRM's Functional Bureau Strategy (FBS) Goals: Goal 1—Save lives, ease suffering, and promote human dignity through efficient and effective humanitarian assistance; Goal 2—Promote and provide interim and durable solutions for populations of concern through U.S. assistance and collaboration with the international community; and Goal 3—Advocate for the protection of vulnerable populations and exert leadership in the international community. The objectives will support Goal 1 by ensuring that PRM targets the most vulnerable populations in humanitarian crises with effective health programming. The objectives will support Goal 2 by focusing on both COVID-19 response and recovery phases and promoting the integration of PoCs into national systems for health, immediate economic relief, and longer-term economic recovery programs. The objectives will support Goal 3 by advocating for the inclusion of PoCs in national COVID-19 response and recovery plans. These include vaccine distribution plans supported by the USG, partner nations,

and international organizations such as Gavi, the Vaccine Alliance. The objectives will also support Goal 3 by addressing specific protection needs of COVID-19-affected PoCs, including increased GBV, MHPSS, and protection of children whose schools have closed.

References

Acarturk, C., E. Uygun, Z. Ilkkursun, K. Carswell, F. Tedeschi, M. Batu, S. Eskici, G. Kurt, M. Anttila, T. Au, J. Baumgartner, and R. Churchill. (2022a) Effectiveness of a WHO self-help psychological intervention for preventing mental disorders among Syrian refugees in Turkey: a randomized control trial. World Psychiatry. 11 January 2022

Acarturk, C., E. Uygun, Z. Ilkkursun, T. Yurtbakan, G. Kurt, J. Adam-Troian, I. Senay, R. Bryant, P. Cuijpers, N. Kiselev, D. McDaid, N. Morina, Z. Niscanci, A.L. Park, M. Sijbrandiji, P. Ventevogel, and D.C. Fuhr. (2022b). Group problem mangaemnt plus to decrease psychological distress among Syrian refugees in Turkey: a pilot randomised controlled trial. BMC Psychiatry. 04 January 2022.

Charlson F, et al. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. Lancet. 2019 Jul;394(10194):240–8.

Chisholm, Dan on behalf of WHO-Choice (2005) Choosing cost-effective interventions in psychiatry: results from the CHOICE programme of the World Health Organization. World Psychiatry. Vol. 4(1) 2005 February

Doctors Worldwide (YYD) (2021) Community Centers for Refugees and Vulnerable Host Communities to Provide Psychosocial Support and Protection Services: Need Assessment of COVID-19 Pandemic Impact in Istanbul especially for Afghan Groups (funded by European Union, Alman, and GiZ)

Department of State (2021) Congressional Budget Justification: Department of State, Foreign Relations, and Related Programs, FY2022. https://www.state.gov/wp-content/uploads/2021/05/FY-2022-State_USAID-Congressional-Budget-Justification.pdf

Department of State, Bureau for Population, Refugees, and Migration (PRM) (2021) FY2021-2022 Strategy for COVID-19 Response and Recovery: Annual Performance Review, December 2021

_____ (2021) Policy and Program Review Committee (PPRC): FY 2021-FY 2022 Strategy for COVID-19 Response and Recovery. Sensitive But Unclassified Memorandum.

____ (2018). Policy and Program Review Committee (PPRC): FY 2018-FY 2021 Health Strategy Paper. Sensitive But Unclassified Memorandum.

Fortify Rights (2020). The Torture in My Mind: The Right to Mental Health for Rohingya Survivors of Genocide in Myanmar and Bangladesh, US and Switzerland

Harrison, Sarah et al. (2020) MHPSS-and-Protection outcomes. Global Protection Cluster and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. Policy Discussion Paper, September 2020, Geneva. https://www.globalprotectioncluster.org/wp-content/uploads/MHPSS-and-Protection.pdf

International Medical Corps (2021) Guidelines for MHPSS Staff Providing Tele-MHPSS to Clients During the COVID-19 Pandemic. Field Test Version 24.04.20.

IASC (2017) Mental Health and Psychosocial Support in Emergency Settings, Monitoring and Evaluation, IASC, Geneva.

Inter-Agency Standing Committee (IASC) (2021). IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: With means of verification (Version 2.0). https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-emergency

Inter Sector Coordination Group (ISCG) (2020) Joint Multi-Sector Needs Assessment (J-MSNA). Host Community. Cox's Bazar, Bangladesh.

International Organization for Migration (IOM) (2020) Mental Health and Psychosocial Support in the COVID-19 Response: Guidance and Toolkit for the Use of IOM MHPSS Teams.

IOM (2021) Early marriage. Awareness or Psychoeducation Session, MHPSS Team, Cox's Bazar

____ (2021) Suicide Prevention: Creating Hope Through Action (Powerpoint for awareness raising during Suicide Awareness Month - September), IOM MHPSS Team, Cox's Bazar

____ (n.d.) Family Dialogues Manual, MHPSS Team, Cox's Bazar

____ (n.d.) Group session conflict mediation manual, MHPSS Team, Cox's Bazar

____ (n.d.) Healing Ceremonies Structure, MHPSS Team, Cox's Bazar

____ (n.d.) Psychoeducation session on "Covid-19 and Psychosocial Wellbeing", MHPSS Team, Cox's Bazar

____ (n.d.) Suicide Prevention Awareness Raising Session, MHPSS Team, Cox's Bazar

Jeffries, Rosanna et al. (2021) The health response to the Rohingya refugee crisis post August 2017: Reflections from two years of health sector coordination in Cox's Bazar, Bangladesh. PLOS ONE. June 11, 2021

Rice-Oxley, Mark (2019) Mental illness: is there really a global epidemic? The Guardian.pdf Monday 3 Jun 2019

Riley, Andrew, Yasmin Akther, Mohammed Noor, fourth author redacted, and Courtney Welton-Mitchell (2021). Mental health and conditions in refugee camps matter when Rohingya living in Bangladesh consider returning to Myanmar. May 10, 2021. Humanitarian Practice Network.

Riley, Andrew, Andrea Varner, Peter Ventevogel, M.M. Taimur Hasan (UNHCR) and Courtney Welton-Mitchell (University of Denver) (2017). Daily stresses, trauma exposure, and mental health among stateless Rohingya refugees in Bangladesh. Transcultural Psychiatry 2017. Vol 54(3): 304-331.

Sagar-Ouriaghli, I., E. Godfrey, L. Bridge, L. Meade, and J.S.L. Brown. (2019). Improving Mental Health Utilization Among Men: A Systematic Review and Synthesis of Behavior Change

Techniques Within Interventions Targeting Help Seeking. American Journal of Mens Health 13(3). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6560805/

Silove D, Ventevogel P, Rees S. The contemporary refugee crisis: an overview of mental health challenges. World Psychiatry. 2017 Jun 1;16(2):130–9.

Tay, A.K. et al. (2018) Culture, Context and Mental Health of Rohingya Refugees: A review for staff in mental health and psychosocial support programmes for Rohingya refugees. UNHCR, Geneva.

Tay, A.K. H.K. Mung, M.A.A Miah, S. Balasundaram, P. Ventevogel, M. Badrudduza, S. Khan, K. Morgan, S. Rees, M. Mohsin, and D. Silove. (2020). An Integrative Adapt Therapy for common mental health symptoms and adaptive stress amongst Rohingya, Chin, and Kachin refulgees living in Malaysia: A randomized controlled trial. Plos Medicine, published 31 March 2020. https://doi.org/10.1371/journal.pmed.1003073

Terre des Hommes (2021) PRM Project Intervention (Health) September 2019 – August 2021. Powerpoint Presentation.

United Nations (2020). Policy Brief: COVID-19 and the Need for Action on Mental Health. 13 May 2020.

United Nations High Commissioner for Refugees. (2013). Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations.

UN High Commissioner for Refugees (UNHCR). (2014). Child protection Issue Brief : Mental health and psychosocial well-being of children. January 2014.

United Nations High Commissioner for Refugees (UNHCR) (2021a) Refugee Data Finder: Key Indicators.

United Nation High Commissioner for Refugee (UNHCR) (2021b). Global Strategy for Public Health (2021-2025). UNHCR.

UNHCR (2021c) COVID-19 poses a major threat to the life and welfare of refugees in Uganda. 17 June 2021

UNHCR (2021d) Strengthening Mental Health and Psychosocial Support in 2021. UNCHR, Geneva.

UNHCR (n.d.) Emerging Practices: mental health and psychosocial support in refugee operations during the COVID-19 pandemic.

United Nations Childrens Fund (UNICEF) (2021) On My Mind: Promoting, Protecting and Caring for Children's Mental Health. The State of the World's Children. Executive Summary. October 2021, New York.

Weissbecker Inga et al. (2019) Integrative Mental Health and Psychosocial Support Interventions for Refugees in Humanitarian Crisis Settings. In: An Uncertain Safety. Springer International Publishing; 2019. p. 117–53.

WHO/Bangladesh (n.d.) Unpublished paper

WHO (2021) Mental Health Atlas 2020. Geneva.

WHO (2021) Mental health and forced displacement: Key Facts. 31 August 2021. Geneva

WHO (2020) Doing What Matters in Times of Stress: An Illustrated Guide. Geneva

WHO (2011) Psychological first aid: Guide for field workers. Geneva

WHO (2013) Building Back Better: Sustainable Mental Health Care after Emergencies. Geneva.

WHO and UNHCR (2015) mhGAP Humanitarian Intervention Guide. Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies. Geneva.

WHO and UNHCR (2012) Assessing Mental Health and Psychosocial Needs and Resources: toolkit for humanitarian settings.

Annexes

Annex 1: Country Specific Programming Recommendations

The following lists provide targeted programming recommendations from service users and service providers in Turkey and Bangladesh. They have been edited for clarity and to remove duplication, but they have not been analyzed. PRM RefCoords in each country may share these with IO and NGO partners as appropriate for consideration to strengthen programming. Some of these recommendations go beyond direct MHPSS support, but may work to address drivers' of MHPSS concerns, such as limited ability to generate income. In some cases, some PRM grantees are already providing similar services (both MHPSS and non-MHPSS), and it may be helpful for PRM RefCoords to facilitate skill sharing, coordination, and referral as appropriate. Some recommendations here may also be useful/applicable for country programming in other countries. PRM RefCoords in other countries may circulate applicable recommendations.

Turkey Programming Recommendations

Service providers and service users recommend that **program content for adults** include**:**

- Increased programming in service user languages, including Arabic, Kurdish, Farsi, and Dari
- Turkish language acquisition, particularly vocabulary for hospitals and other health care settings for when translators are not available, including both in-person and online options
- Training on Turkish laws, refugee rights, registration procedures, asylum applications, and Turkish culture/norms
- Legal advocacy and negotiation

- Activities to support income generation, including small amounts of venture capital, provision of initial raw materials, provision of tools such as sewing machines, business start-up training (including for online businesses), and vocational training
- Provision of materials to address basic needs depending on the needs of individual families, including food vouchers, hygiene and WASH kits, pregnancy and infant care kits, mobility aids such as wheelchairs, and education kits
- Provision of materials for rest and relaxation, including books, sports equipment, instruments, and crafting supplies
- Financial support for transportation (approximately 100 lira/month depending on location)
- Community activities, such as games, picnics, tickets to football matches, and field trips, including outdoor activities specifically for women only
- Increased messaging against child marriage
- Facilitated interactions and communication with UN agencies on behalf of service users in order to ensure service users case information is transferred during referral and to ensure service users are aware of how the systems work

Service providers and service users recommend that **program content for children** include**:**

- Programming to address TV and internet addiction, which some parents see as a driver of MHPSS concerns for their children
- Programming to address suicidal thoughts
- Messaging against child marriage
- Services for girls experiencing early marriage

- Activities designed for children with physical and mental disabilities
- Confidence building activities (particularly for girls)
- Turkish language programming
- Outdoor group activities
- Art/art therapy activities

Service providers and service users recommend that **programs with host communities** include**:**

- Movie nights for refugee and host community members to attend together and build cross community relationships and trust
- Training for teachers to recognize and intervene in cases of bullying against refugee children
- Training for teachers to recognize and prevent when they themselves stigmatize and harm refugee children

Service providers and service users recommend that **program outreach** include**:**

- Increased use of social media to disseminate information about MHPSS services available
- Increased messaging on social media to destigmatize mental health services
- Increased budget for developing virtual brochures and pamphlets in service user languages for outreach online and targeted budget for printing copies to reach populations without internet access

Service providers and service users recommend that **program locations** include**:**

- One stop service centers that can service users' basic needs, health needs, MHPSS needs, and provide internet access
- Satellite centers to address needs in rural areas
- Women friendly and child friendly safe spaces
- Childcare services so that adults (particularly women) can participate in programs OR drop children off so they can work
- Wider catchment areas for mobile teams so they do not need to deny services to unserved communities
- Online locations for virtual/hybrid programming

Service providers recommend approaches to address **staffing needs**, including**:**

- Training for community volunteers to provide basic MHPSS services
- Training for MHPSS supervisors
- In-person training on key topics, including drama therapy, art therapy, specialized therapies for level four needs, and approaches to working with people from different cultural backgrounds
- More funding to provide staff self-care and promote work-life balance, particularly for translators since they do not always have mental health training to fallback on
- New graduate training programs, including restarting the MHPSS graduate certification program

Bangladesh Programming Recommendations

Service providers and service users recommend that **program content for adults** include:

- Support for single or widowed women in the form of financial and MHPSS support
- Programming for couples focused on transforming gender norms and roles in the household, including sessions on educating husbands and mother-in-law.
- Training on vocational skills that will lead to job opportunities and contribute to the household income, including handicrafts or sewing
- Increased legal support for GBV survivors
- Programming for caretakers, specifically spouses of persons with disabilities
- Increase frequency of MHPSS programming sessions to once or twice a week
- Conducting community awareness sessions in the community rather than health centers
- Developing appropriate messaging to build awareness and reduce the stigma of MHPSS.
- More MHPSS sessions on techniques to manage tension and stress
- Integrating surgery-level care in the health centers in the camps
- Programming on preventing suicide and drug-abuse
- Audit medicine distribution to ensure equitable distribution and reduce medicine resale
- Expansion of medicine list, including the need for Hepatitis C medication and treatment
- Improving ventilation in health centers

Service providers and service users recommend that **program content for children and youth** include:

- Programming for caretakers to support children with neurodevelopmental or physical disabilities to provide appropriate medical care and prevent burnout
- Formal education in the camps for children and youth at appropriate learning levels
- Regular community activity sessions for children with sports, arts, music, and games
- Integrating educational activities with imams and school teachers
- Training for staff on MHPSS programming specifically for children, which includes emotional regulation and management.
- Youth empowerment programs to help youth be more involved in the community, such as building leadership and health-related skills (blood pressure checks, Cardiopulmonary resuscitation (CPR), sexual health awareness, etc.)
- Programming on preventing child marriage, anti-trafficking, and child protection for young girls
- Create formal child-friendly spaces in the health centers in the form of specific playrooms or a play corner in the rooms that parents receive MHPSS counseling.
- Programming on preventing drug-abuse for youth and drug rehabilitation services at health centers.

Service providers recommend approaches to address **staff training and human resources**, including:

- Recruitment methods for specialized MHPSS staff, such as clinical psychologists and psychiatrists, at the health centers to provide regular counseling sessions, diagnoses, and psychotropic medications
- MHPSS programming for staff to discuss their own secondary trauma, self-care, and burnout

- In-person, not online, MHPSS training to build capacity of staff in various therapeutic techniques such as CBT, behavior therapy, IAT, IPT, ISG, DBT, EMDR, NRT, and positive parenting
- Develop creative and sustainable training modalities to retain staff
- Increased training and supervision for community para-counselors, specifically on suicide prevention and family therapy
- Training focused on child MHPSS and specifically on children with disabilities and special needs.
- Increased number of MHPSS staff, such as psychologists and psychiatrists, at the camps so that they are available daily and not based on a rotation
- Basic MHPSS training for all staff, regardless of sector
- Programming focused on building capacity of community members, such as capacity building for community volunteers
- Training focused on group counseling sessions on spousal relationships, anger management, and stress management
- Placing MHPSS staff at government hospitals for emergency cases
- Advocacy with government to ensure MHPSS is a required part of health programming

Service providers and service users recommend that **programs with host communities** include:

- Secure and safe health structure for the host community to access MHPSS services
- Continuing health services and scaling up of MHPSS services for the host community

Annex 2: Evaluation Team

Evaluation Team

Dr. Lynellyn Long, PhD: Team Lead

Ted Rizzo: Evaluation Specialist II (design of data collection tools, conduct interviews in Turkey, survey lead, interview coding, qualitative and quantitative data analysis, report writing)

Gayatri Malhotra: Evaluation Specialist I (design of data collection tools, conduct interviews in Turkey and Bangladesh, qualitative and quantitative data analysis, report writing)

Lane Benton: Project Coordinator (project management, administrative management, travel management, interview coding, qualitative and quantitative data analysis, report writing)

Kate Batchelder: Evaluation Specialist II (interview coding, quantitative and qualitative data analysis, report writing)

Dr. Jonathan Jones, PhD: Corporate officer

Team Qualifications and Experience

Lynellyn Long, PhD

Since the late 1970s, Dr. Lynellyn Long has worked in international humanitarian and development assistance. She has led large-scale international programs to address trauma and rape as a weapon of war, violence against women and children, human trafficking, women's livelihoods, girls' education, and reproductive health/HIV research, financing, and training. Her work has included organizing refugee returns and reintegration in the Balkans; addressing human trafficking and labour exploitation in Southeast Asia, Central and Eastern Europe, West Africa, and the Middle East; and resettling Ukrainians in Europe. Having worked in outright, protracted and post conflict situations, Dr. Long has extensive experience in interviewing and

working with trauma survivors. In 2019, she led DOS/BPRM's first evaluation of its Safe from the Start (SftS) program. As a AAAS and subsequent Johns Hopkins Fellow at USAID, she conducted joint assessments with BPRM in the Mozambican refugee camps in Malawi; the Khartoum displaced in Sudan; and survivors during the Balkans war. Dr. Long has published academic articles on refugee and migrant health and mental health, and taught graduate courses at American, Johns Hopkins School of Public Health, and Tufts University. She has also trained graduate research teams at Harvard and Tufts, and senior managers and monitoring and evaluation specialists at the World Bank, Population Council, IOM, and Amnesty International on qualitative and quantitative research design and analysis, situation analysis, sampling, human subjects' protocols, and reporting guidelines.

Ted Rizzo

Ted is a monitoring, evaluation, and learning specialist II with over eight years' experience in the international development and humanitarian response sectors with a particular focus on the Middle East and North Africa and Sahel regions. Ted has supported evaluations of programs focused on girls' education, youth development, sexual and reproductive health, gender-based violence, and child marriage in both crisis and conflict as well as post-conflict settings. Ted is professionally proficient in both Modern Standard and Moroccan Arabic and has a working knowledge of Levantine Arabic.

Gayatri Malhotra

Global health professional with 7 years of monitoring, evaluation, research, and learning (MERL) experience focused on gender equality, women's health, adolescent health, youth education, sexual and reproductive health (SRH), gender-based violence (GBV), corruption, and communications. Demonstrated experience with mixed-methods study design, quantitative and qualitative data collection, and developing research instruments with strong understanding of data management and intermediate statistical analyses. Knowledgeable in logic models, research study design, M&E frameworks, evaluations (impact, performance, program, and outcome), need or readiness assessments, and communicating research findings to various

audiences. Educational certification includes a Master of Public Health in Global Health Epidemiology and Disease Control. Languages include native fluency in English and native proficiency in Hindi.

Lane Benton

Lane is a project coordinator on EnCompass' Technical Assistance and Evaluation team. Lane has over 5 years of experience in project management and global development. She has worked in low-income international settings and multinational nonprofits. Lane holds Bachelor of Arts degrees in both Global Health and International Affairs and speaks English, Setswana, and some Spanish. She has experience in software including Excel, ArcGIS, and R.

Kate Batchelder

Kate Batchelder is a Monitoring and Evaluation (M&E) Specialist at EnCompass. She has extensive involvement in evaluations primarily in the field of international education as well as adjacent sectors. She has managed the implementation of and contributed to data analysis and findings reports for studies ranging from small data collection instrument pilots to nationally and regionally representative evaluations. Kate holds an MA from Columbia University, Teachers College and a BA from Bates College.

Jonathan Jones, PhD

Dr. Jonathan Jones is the Director for Evaluation at EnCompass LLC and member of the Senior Management Team. He has 15 years of research experience, having led complex M&E efforts in more than 20 developing countries and conducted hundreds of interviews and focus groups, often in difficult/sensitive environments. Dr. Jones is a thematic expert in M&E of governance and democracy assistance programs. Dr. Jones offers experience developing regional MEL systems. For the Department of State, as part of an evaluation of its Global Equality Fund LGBTI human rights portfolio, Dr. Jones developed the initial framework and guidance to establish a global MEL system. He undertook a similar initiative for the Margaret A. Cargill international

relief and resilience portfolio. At the International Republican Institute, Dr. Jones developed standardized tools, data collection, and storage processes to enable aggregation of country data. He is currently serving as the Corporate Officer/Senior Technical Advisor for the USAID/Peru MELS activity, which technical and advisory MEL assistance for USAID/Peru and its bilateral and South America Regional portfolios, USAID/Brazil, and USAID/Paraguay. Further, Dr. Jones has supported capacity building on key M&E concepts and approaches, including developing meaningful theories of change, setting objectives, developing measures, conducting data collection and analysis, evaluation use, and conducting evaluation in an ethical manner. He has also designed and delivered training on M&E for international development funders and partners. He has significant experience in participatory approaches to evaluation and ensures that the evaluation process is useful for key audiences.

Annex 3: Evaluation Scope of Work

U.S. Department of State

Bureau of Population, Refugees, and Migration (PRM)

Evaluation of PRM-Supported Initiatives on Mental Health and Psychosocial Support (MHPSS)

Item number	Project Deliverables	Percent	Amount
1	Kickoff Meeting	3%	$10,170.75
2	Evaluation Workplan	7%	$23,731.75
3	Desk Review/Inception Report	10%	$33,902.50
4a	Written and Oral Progress Reports (month 4)	15%	$50,853.75
4b	Written and Oral Progress Reports (month 8)	15%	$50,853.75
5a	Completion of in-country field work (Country #1)	15%	$50,853.75
5b	Completion of in-country field work (Country #2)	15%	$50,853.75
6	Final Report	20%	$67,805.00
	Total Labor – Firm-Fixed Price		**$339,025.00**

The purpose of this requirement is to obtain the services of a contractor to carry out an external evaluation, lasting up to 10 months of PRM-supported initiatives to address and integrate into broader programming the mental health and psychosocial support (MHPSS) needs of PRM populations of concern (PoC), i.e., refugees, internally displaced persons (IDPs), stateless persons, conflict victims, and vulnerable migrants. The evaluation will consist of:

- A comprehensive desk review and analysis of relevant literature, reporting by PRM partners, and best practices in MHPSS programming for refugees, IDPs, and other conflict-affected populations

- Fieldwork (remote if necessary) to examine PRM-supported MHPSS programming inclusive of both international organization (IO) and nongovernmental organization (NGO) programming, in Geneva, Switzerland (for international humanitarian organizations based there) and two countries to be determined jointly by evaluator and PRM

- A final evaluation report incorporating concrete recommendations that will inform PRM's future MHPSS policy and programming and strengthen the effectiveness of PRM-funded efforts to integrate MHPSS into PRM-funded humanitarian assistance

This evaluation is intended to support the development of the Bureau's MHPSS strategies by:

- Distilling the most relevant issues in MHPSS research and practice in humanitarian response.

- Providing concrete inputs to PRM on ways to tailor overseas assistance aimed at addressing and meeting the MHPSS needs of PRM's PoC

In 2013, PRM funded an International Medical Corps (IMC) research project that assessed comprehensive mental health service provision programming aimed at refugees and the vulnerable host population in Jordan and developed a comprehensive and standardized Mental Health Case Management (MHCM) training package and accompanying monitoring and evaluation tools. However, no formal evaluation of PRM's programmatic efforts to address the MHPSS needs of its PoC globally through support provided by both its IO and NGO partners has been undertaken.

The desk review, consultations, and analysis undertaken via this evaluation will focus on the following areas:

- Overall performance of PRM-supported MHPSS initiatives in meeting the needs of refugees and IDPs

- Extent and effectiveness of MHPSS when integrated with other sectors of PRM-supported programs (such as but not limited to protection, health, and education programming) including perceptions of beneficiaries with regard to the assistance they have received

- Identifying best practices and areas for improvement in how PRM supports the MHPSS needs of its populations of concern

The primary audience for the evaluation is PRM and its IO and NGO partners. Evaluation findings should be targeted, concrete, actionable, and tailored to the work of PRM and its partners. Unless doing so raises security or other concerns, the final evaluation report will be shared publicly and/or posted for external consumption.

Background and Current Efforts

PRM

PRM's mission is to provide protection, ease suffering, and resolve the plight of persecuted and uprooted people around the world on behalf of the American people by providing life-sustaining assistance, working through multilateral systems to build global partnerships, promoting best practices in humanitarian response, and ensuring that humanitarian principles are thoroughly integrated into U.S. foreign and national security policy. PRM's humanitarian assistance, coupled with diplomacy, forms an essential component of U.S. foreign policy by helping to strengthen bilateral and multilateral engagement with crisis-affected countries. The United States government is the largest bilateral donor to UNHCR (through PRM) and ICRC and among the largest bilateral donors to IOM and UNICEF (through PRM and other USG sources). PRM also funds NGOs to fill critical gaps in the programming of multilateral organizations, host

governments, and other donors. The Bureau's humanitarian diplomacy efforts to advance protection and durable solutions are as critical as its assistance programs.

PRM often funds NGO activities in 12-month increments, although in recent years it has encouraged NGO partners to apply for multi-year funding as part of its Grand Bargain commitments, and an increasing proportion of its NGO awards are multi-year in scope. Through humanitarian diplomacy, PRM engages partner governments on policy initiatives to improve outcomes and solutions for populations of concern. Strong monitoring and evaluation (M&E) contributes to the identification of best practices, both political and programmatic, that can be promoted in the provision of humanitarian assistance. Monitoring the performance of PRM partners and the effectiveness of PRM assistance is a responsibility shared by D.C.-based PRM Program Officers and their respective Regional Refugee Coordinators, as well as other staff with responsibility for humanitarian issues based at U.S. embassies throughout the world. This staff is supported by training as well as sectoral, institutional, and M&E expertise provided by PRM's Offices of Policy and Resource Planning (PRP) and Multilateral Coordination and External Relations (MCE).

Upon award of this contract, PRP will work closely with the contractor for the duration of the evaluation, with support from other offices as needed. In accordance with the standards of good management and performance-based results, the contractor will be held accountable for cost, schedule, and performance results.

MHPSS

The Inter-Agency Standing Committee (IASC) uses the term 'mental health and psychosocial support' to refer to any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders. Among humanitarian agencies, the term is widely used and serves as a unifying concept that can be referenced by professionals in various sectors. MHPSS interventions can be implemented in any sector of programming but are most frequently found in programs for health and nutrition, protection (community-based protection, child protection, and/or GBV), and education.

The term ‘MHPSS problems’ may cover a wide range of issues including social problems, emotional distress, common mental disorders (such as depression and post-traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual or developmental disabilities. For those experiencing MHPSS problems, displacement and humanitarian crises disrupt or erode protective structures that are normally available, increase the risks of diverse problems, and may amplify preexisting problems. Mental health and psychosocial problems in emergencies are highly interconnected, but can be social or psychological in nature and pre-existing, emergency-induced, or humanitarian aid-induced.

The IASC outlines the distinction between mental health and psychosocial support but recommends a layered response to meet a broad range of needs. Further, problems of a predominantly social nature, which often are disproportionately underrepresented and underfunded among MHPSS programming, may contribute or exacerbate mental or psychological problems. As such, MHPSS is an integral part of any humanitarian response, including in acute or rapid-onset emergencies and protracted situations. In situations of protracted displacement, mental health and psychosocial activities are vital interventions to assist communities in drawing on and building resilience to cope with stress associated with long-term displacement, as well as peace-building and civil society partnerships.

It is important to build understanding of MHPSS across all sectors, to reduce the burden of mental illness, improve the ability of refugees to function and cope, and strengthen resilience. To this end, humanitarian actors should adopt an MHPSS approach and integrate MHPSS interventions in field operations as a priority. Such activities are usually implemented via projects in health, community-based protection, GBV, child protection, and education. MHPSS activities that are integrated in wider systems or embedded in community support mechanisms and that actively engage beneficiaries to determine their self-identified needs and priorities regarding their care, are likely to be accessible to more people, are often more sustainable, and tend to carry less stigma.

PRM-Supported MHPSS Programming

Working to address MHPSS supports all three of PRM's Functional Bureau Strategy Goals:

1. Save lives, ease suffering, and promote human dignity through efficient and effective humanitarian assistance.

2. Promote and provide durable and interim solutions for populations of concern through U.S. assistance and collaboration with the international community.

3. Advocate for the protection of vulnerable populations and exert leadership in the international community.

PRM's current MHPSS strategy, as informed by the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings and its associated MHPSS intervention pyramid, is folded into the Bureau's broader FY 2018-2021 Health Strategy and emphasizes the improvement of access to MHPSS services for PRM's populations of concern. Current objectives include increasing USG advocacy and technical support for MHPSS programming through PRM's IO and NGO partners, building stronger relationships with organizations that have MHPSS expertise, and developing policy direction for the Bureau to include MHPSS in future funding opportunities. Objective milestones include:

- MHPSS is included as part of a multi-sectoral humanitarian response.

- Where appropriate, MHPSS services are integrated in standard refugee health responses.

- New IO and NGO partners are identified by PRM to deliver MHPSS services.

- PRM NOFOs include MHPSS as a prioritized sector where appropriate.

- Increased engagement between PRM and other organizations such as the World Health Organization (WHO) on MHPSS to enhance programming.

PRM's IO Partners

PRM supports UNHCR in its coordination of MHPSS activities that directly impact its PoCs in the field. In addition to providing guidance to field staff and partners, especially through UNHCR's Emergency Handbook, UNHCR implements its MHPSS programming through community-based protection systems and existing interventions, prioritizing working partnerships with refugee communities and bolstering existing health systems while advocating for the inclusion of refugees into national health systems and for the integration of mental health into primary health care. UNHCR also invests in training of health staff to identify and manage priority refugee mental health conditions, non-specialists on brief forms of psychological therapy, and in some situations, funding mental health professionals to address more complex refugee mental health conditions.

ICRC's 2014–2018 Health Strategy included MHPSS in its strategic objective that aims to respond to new and emerging health needs among people affected by armed conflict and other situations of violence. ICRC's MHPSS activities include: provision of therapeutic services – psychological or medical; provision of individual and group psychosocial support; training in MHPSS skills and follow-up supervision for first responders and key community leaders; sensitization, awareness raising and psychoeducation on MHPSS issues; and community mobilization. In order to ensure a continuum of care, ICRC MHPSS programs are, where necessary, integrated into the overall health response.

IOM provides direct MHPSS to migrants, emergency affected individuals, and host communities throughout its programs in efforts to mainstream MHPSS into migrants' protection. Emergency response and humanitarian activities include: deployment, training, and supervision of multidisciplinary Psychosocial Mobile Teams; establishment of temporary Psychosocial Support hubs in camps and host communities; referral mechanisms for those with severe mental disorders; interpretation, mediation, and national mental health system strengthening; and strengthening and implementation of community-based supports aiming at mending social fabrics and promoting social cohesion. Within the health sector, IOM also focuses on capacity building of service providers in mental health and population mobility and for mainstreaming

interpretation, mediation, outreach to diverse populations and cultural diversity awareness in mental health services.

Other PRM IO partners include the WHO, which provides guidelines and programming, particularly the Mental Health Gap Action Program (mhGAP) aimed at scaling up services for mental, neurological and substance use disorders, and which contributes intervention manuals, policy directions, and other tools to support the emergency response for mental health. WHO also co-chairs the IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings, which provides advice and support to organizations working in emergency settings. PRM also funds UNICEF in its efforts to develop communities' capacity to support child and family well-being through activities like awareness raising on child distress reactions and programs that facilitate mental health care and provide clear information about children's mental health and psychosocial needs to help communities take action.

PRM-funded NGO Programming and Efforts

PRM funds NGOs, including but not limited to the Hebrew Immigrant Aid Society (HIAS), International Medical Corp (IMC), the Jesuit Refugee Service (JRS), and the Center for Victims of Torture (CVT), to fill in critical gaps and provide socially and culturally relevant assistance and advocacy to address MHPSS needs. Often these NGO programs are intended to bolster specific layers of intervention support.

For example, PRM funds HIAS programming in Africa and Central America, where services offered include integrated and stand-alone psychosocial activities that are tailored to each community and to individual refugees. Programs are implemented in community-based psychosocial settings and include: capacity-building of community leaders and members to provide basic psychosocial support and to refer refugees in need of more advanced care; providing training for partner organizations and national institutions on key MHPSS topics; and facilitating individual and group counseling for children, adolescents, and adults experiencing emotional distress.

IMC programs funded by PRM for implementation in Africa and the Near East are focused on working with traditional community-based support groups and key people who can offer basic psychosocial support within the community, training medical and non-medical professionals to strengthen national health systems (particularly to address refugee crises), and linking existing community support groups with local doctors and nurses trained by IMC to strengthen and expand the continuum of care from the community level to other local, regional and national health facilities. In some cases, IMC hires psychiatrists, embedding them in primary health care systems, to respond to the mental health needs of refugees and host communities supporting the host-government medical system and paving the way for expanded recognition of mental health needs.

PRM funds JRS in Africa to provide intervention groups for vulnerable groups, case management services, individual and group counselling, and training and supervision of non-specialists recruited from the beneficiary communities.

PRM funds CVT programs in Africa and the Near East that administer both mental health counseling, psychosocial support, and physiotherapy for clients with a spectrum of functionality. CVT's mental health services undertake a thorough assessment and treatment plan to increase functioning of survivors of torture or trauma. CVT trains local clinical staff, in some cases refugees and survivors of trauma themselves, in order to utilize the host community to build a referral system, and also trains local health government officials in basic MHPSS interventions.

Recent Developments

Within the context of the COVID-19 pandemic, PRM has identified MHPSS as an area of critical importance for its populations of concern and MHPSS is a key objective in PRM's FY2021-2022 COVID-19 strategy. According to the WHO, in conflict settings as many as one in five people has a mental health condition. The situation of the pandemic may exacerbate existing mental health conditions, induce new conditions, and overwhelm already scarce mental health services. Anxiety about the pandemic, reduction of economic well-being, increased instances of

GBV, and lowered levels of humanitarian assistance during COVID-19 have increased risk factors for an already vulnerable population. These circumstances, coupled with the persistent lack of consistent data on the mental health of migrants, present a challenge to PRM and its partners in providing MHPSS to its PoC.

Across the international humanitarian response to the COVID-19 pandemic, there have been efforts initiated to support people in distress and to ensure care for people with mental health conditions. Innovative ways of providing mental health services have been implemented, and initiatives to strengthen psychosocial support have sprung up. Yet, because of the size of the problem, the vast majority of mental health needs remain unaddressed. The response is hampered by the lack of investment in mental health promotion, prevention and care before the pandemic.

Evaluation Questions

The purpose of the evaluation is to:

- Assess PRM-supported efforts to address MHPSS
- Develop recommendations that can be used to update PRM's MHPSS strategy and strengthen programming and advocacy conducted by PRM and PRM partners

The final evaluation report should answer the following questions, drawing on both the field work and the desk study as appropriate, with an emphasis on developing best practices, lessons learned, and actionable recommendations to inform the programming and advocacy of PRM and its partners. The lettered sub-questions under each numbered main question are meant to further clarify the main question.

1. To what extent have PRM-supported programs, both IO and NGO, contributed to meeting the MHPSS needs of refugees and IDPs?
    a. Did MHPSS programs target and reach those most in need? Did they follow international best practices (such as the IASC MHPSS guidelines)?

b. Were stand-alone MHPSS programs effective?

c. Were efforts to integrate MHPSS into other sector responses (such as but not limited to protection, health, and education) effective?

d. How well have PRM-supported NGO activities addressed gaps in IO programming to meet MHPSS needs?

e. Which activities were more (or less) successful in meeting their goals and why?

2. How have PRM partners integrated the needs and perceptions of beneficiaries of PRM-funded programs into the planning, development, and evaluation of their MHPSS programming?

   a. Do beneficiaries report they have been consulted and involved in the process of designing MHPSS interventions, and afforded opportunities to provide effective and ongoing feedback on the quality and utility of assistance provided?

   b. If/how has programming been adapted in response to beneficiary perceptions and feedback?

   c. How have program managers ensured that the feedback received reflects the full diversity of the population served?

3. How has the COVID-19 pandemic affected the efficacy of MHPSS programming from PRM partners (both stand-alone and integrated)?

   a. How did implementing partners adapt to the circumstances of the pandemic to maintain MHPSS programming and what were the factors that facilitated adaptations?

   b. How have implementing partners' understanding/perception of best practices changed due to the circumstances presented by the pandemic?

4. What changes or updates to PRM's MHPSS strategy would help strengthen the ability of PRM to meet and address the MHPSS needs of its PoC?

    a. Does the existing MHPSS strategy, embedded in the broader health strategy, appropriately inform current funding decisions?

    b. Is the current strategy sufficient to provide a strong foundation for future decisions, including post COVID-19 efforts to build the humanitarian response back 'better'?

    c. What changes or updates would make the strategy a better document for guiding PRM policy and funding decisions?

Evaluation Design and Data Collection Methods

PRM expects that the evaluation will use a mixed method design involving both qualitative and quantitative methods to analyze programming covering the period from FY 2018 to the present. PRM will rely on the contractor to both propose and design the research methodologies to answer research questions in the best and most efficient way possible. It is anticipated that methods will include some combination of desk research/analysis, key informant interviews, group discussions (as relevant), and collection of case studies to produce findings, draw conclusions, and present recommendations. Participation of beneficiaries is required. It is essential that all research is conducted in line with ethical and safety standards and be done in a way that upholds PRM's commitment to professionalism. Ethical approaches to data collection such as obtaining informed consent, maintaining confidentiality, and ensuring referral pathways are established before interviewing will be particularly critical.

Any interviews with beneficiaries must be sensitive to and designed to prevent traumatization. All data collection methods and tools shall be shared with PRM in advance and strive to get the richest and most useful information in the quickest way possible. This is in recognition of the limited time available and significant workload of PRM partners, particularly those that work in the field in ongoing humanitarian emergencies.

COVID-19 Considerations

PRM is cautiously optimistic that by the time this contract is awarded and work begins, and particularly by the time foreign travel is required, COVID-19 restrictions in the United States and abroad may have begun to be lifted. However, the successful bidder should still be prepared for the possible necessity of doing much of the evaluation work, including the fieldwork, remotely.

Evaluation Team

PRM will consider various evaluation team compositions. However, the team conducting the fieldwork must consist of one Senior or Mid-Level Evaluation Advisor or Evaluation Methods/Implementation Specialist and one Senior or Mid-Level Humanitarian Technical Advisor/Subject Matter Expert with MHPSS expertise. Preferably, both positions will have experience in humanitarian settings. The persons filling these positions, and more specifically those who are responsible for field visits and interviews, should also be familiar with refugee and displacement contexts given the mandate and emphasis of PRM's work.

One team member must be designated as a Team Lead who will oversee and be the focal point for the project. There also must be a U.S.-based position that can easily and reliably liaise with PRM regularly on the status of the evaluation. The evaluation team's knowledge, attitude, and skills must demonstrate the ability to complete the following:

1. Initiate a kick-off meeting with PRM technical staff to understand PRM's current MHPSS objectives and efforts and how they align with broader humanitarian objectives, as well as agree on expectations for communication/involvement moving forward.

2. Undertake a desk review of PRM MHPSS program and project documents from FY 2018-2020, as well as literature over the past 5-10 years relating to MHPSS in a humanitarian context, such as the WHO's Mental Health Action Plan 2013-2020.

3. Introduce the MHPSS evaluation to relevant partners and stakeholders to explain its intention, scope, and purpose as well as to answer any questions they have.

4. Initiate headquarters and field-based data collection efforts to understand the way in which PRM MHPSS efforts have affected the lives of our populations of concern.

5. Analyze collected data, design targeted recommendations, and produce a succinct final report that is informed by PRM and partners through regular consultation and engagement.

6. Debrief PRM, partners and other stakeholders, at various points throughout the process and once the final report is completed, as agreed to with PRM.

Qualifications

1. The Evaluation Advisor/Specialist should have experience designing and implementing evaluations for complex humanitarian settings (i.e. camps, settlements or urban areas where refugees/IDPs are concentrated). The Subject Matter Expert should have experience in conducting research on MHPSS and/or working on MHPSS programming or advocacy in humanitarian response contexts. The Team Lead should have experience and a track record of managing large-scale evaluations in a professional, effective, and collaborative manner. Staff not meeting these requirements may be considered in special circumstances, determined by PRM.

2. The evaluation team must be proficient in English (speaking and writing), have familiarity with both technical and humanitarian terms, and possess an ability to translate concepts as well as write in ways that are easily understood by a public audience. For fieldwork that includes interviews with people of a different language, the evaluation team must have someone proficient in that language and/or an ability to identify and hire high-quality interpreters.

3. The evaluation team must have prior understanding of the mandate and work of State Department/PRM and its partners in caring for its PoC, particularly in the area of MHPSS in

humanitarian settings. An understanding of gender- and age- specific sensitivities in the context of MHPSS is also required.

4. The evaluation team must have a thorough understanding and commitment to upholding ethical and safety standards as it relates to researching MHPSS. Familiarity with existing guidelines and a plan for how to protect confidentiality is essential.

5. A commitment to a person-centered approach is imperative throughout the evaluation. This includes ethical approaches to data collection such as getting informed consent, maintaining confidentiality, and ensuring referral pathways are established before interviewing, etc. As such, team members should be familiar and comfortable taking this approach as well as articulating themselves in this way.

6. Evaluation team members may be based in or outside of the U.S. U.S. citizenship is not required.

7. Security clearance is not required.

Contract organizations and people with prior experience and knowledge of PRM is beneficial. In such circumstances, lessons learned from past evaluations shall be taken into account and integrated into the research design.

Timetable And Deliverables

The contractor will begin work within two weeks after the contract award. The duration of the evaluation will be up to 10 months with a planning, implementation, and completion phase.

The contractor shall provide the following outputs and deliverables to PRM during the evaluation period. The timeframe and due dates for each deliverable will be informed by the evaluation start date and design. However, projected or expected delivery dates shall be provided within the original proposal.

1. Kick-off Meeting: A kick-off meeting between PRM and the contractor should be scheduled within two weeks after the award is signed. The meeting will take place at PRM's office in Washington, D.C. The contractor is expected to develop a meeting agenda prior to the meeting and come prepared with documents, ideas, and plans to discuss at the meeting.

2. Evaluation Work Plan: A detailed work plan is due within two weeks after the kick-off meeting. This plan should be as detailed as possible, with a timeline indicating where and when PRM will be consulted or informed, throughout. The work plan shall include the anticipated schedule and logistical arrangements and delineate the roles and responsibilities of members of the evaluation team.

3. Desk Review/Inception Report: A desk review of partner reports, products, and relevant publications is due within 90 days after the start of the contract. The desk review must also include analysis of initial interviews of PRM and IO headquarters staff; contact information will be provided by PRM. The desk review shall include an updated evaluation design document as an annex. The evaluation design document will include a detailed evaluation design matrix (including the key questions, methods, and data sources used to address each question, the data analysis plan for each question and known limitations to the evaluation design. It may include draft questionnaires and other data collection instruments. The desk review shall not exceed 20 pages, not including annexes. PRM will provide feedback on the draft report within 10 business days. The contractor then has 10 business days to finalize the report. Phone calls can be used to resolve any disagreements or provide clarification. A report revisions matrix must also be submitted with the final desk review report, unless discussed and waived by PRM in advance. The evaluators are required to coordinate closely with PRM's Humanitarian Affairs unit in Geneva when planning interviews with Geneva-based IO (UNHCR, ICRC, WHO, IOM) staff.

4. Monthly Teleconferences: Monthly phone calls will be used as opportunities to problem-solve issues that may arise, identify areas for additional PRM support or assistance, create mutual understanding and prevent misunderstandings. The contractor shall arrange the meeting, provide an agenda, and supply brief minutes after the meeting.

5. Progress Reports: The contractor is required to submit two progress reports to PRM. The reports must summarize progress to date and the status of the major activities being undertaken in relation to the work plan; any deviation from the work plan with associated explanations; indications of any problems encountered or expected, as well as proposals for corrective action, as appropriate; and projected activities for the coming reporting period. These reports are due four months and eight months from the start of the contract.

6. Field-based Data Collection: Fieldwork shall include travel to Geneva headquarters of relevant IOs and to two countries, selected by the contractor in consultation with PRM, that have PRM-supported MHPSS activities (both NGO and IO). Options, to be determined in consultation with PRM as part of the desk study/inception report process, include: Bangladesh, Colombia, Ecuador, Jordan, Kenya, South Sudan, Thailand, and Turkey. The total time spent in the field shall be no more than five weeks, with at least two weeks for each of the country visits, not including travel days. This is in recognition of the lack of time and availability of field staff to partake in evaluations, and the importance of their field work. This allows time for consultation with PRM partners and stakeholders (such as NGOs, experts, working groups, etc.). With PRM support, the contractor will consult with the U.S. Embassy prior to data collection activities in-country. Evaluators are required to coordinate closely with PRM's Regional Refugee Coordinators to schedule in-country meetings and interviews with PRM partners. When in the field, a six-day work week is authorized.

    a. **In-country De-Brief:** A debrief meeting shall be scheduled with the PRM Refugee Coordinator (RefCoord) based at the U.S. Embassy before departure from each field location. If appropriate, other relevant stakeholders and partners should attend these meetings. In countries where there is no Refugee Coordinator in country or the Refugee Coordinator is not available during the field visit, this debriefing can happen remotely with advance notice and approval provided by PRM.
    b. **COVID-19 Contingency:** In the case that field-based data collection is not possible due to restrictions in response to the COVID-19 pandemic, the successful contractor will be expected to devise alternative methods to collect the desired information, such as

video- and/or teleconferencing and on-line surveys, in consultation with PRM. Contractors are strongly encouraged to include such potential options in their proposals.

7. Final Report:

   a. The contractor must deliver a draft final report incorporating findings from the desk review and fieldwork at least 45 days before the completion date of this contract. The final report shall include the following:

      - Executive summary
      - Description of MHPSS initiatives
      - Evaluation purpose and scope
      - Evaluation design and data collection methods
      - Data and findings
      - Conclusions
      - Recommendations
      - Annexes: SOW, research instruments, ethical considerations, details about data collection, etc.

   b. Recommendations shall be concrete, actionable, and tailored to PRM so as to inform the initiative and funding decisions going forward. Recommendations that are detailed, extremely relevant, and limited in number are preferred.
   c. The final report shall include reference to how MHPSS initiatives meets PRM's Functional Bureau Strategy (FBS) objectives. PRM will provide the contractor with an electronic version of the FBS as well as any other strategy documents that may be useful.
   d. The final evaluation report shall be no more than 30 pages in length, exclusive of executive summary and annexes. It must be compliant with Section 508 of the Disabilities Act to facilitate public posting on state.gov. The final report must also

include an executive summary, which shall be no more than five pages. The goal is for the report to be readable, useful, and targeted.

e. PRM will provide feedback on the draft report within 15 business days. The contractor then has 10 business days to complete the report after it is returned by PRM. A revisions matrix must also be submitted with the final report, unless waived by PRM. The final report is intended to be shared publicly on the State Department's foreign assistance evaluations web page and must be in compliance with section 508 of the Rehabilitation Act.

8. Evaluation Summary for Dissemination: A summary of the evaluation shall be written to be made available for a public audience and sent separately from the evaluation report. The summary should be brief, not more than two pages, and should include a short overview of the evaluation, evaluation questions, data collection methods, findings, and recommendations. It should not include confidential issues or anything that is deemed inappropriate or irrelevant to the public. PRM will provide a template for this summary. It should be submitted for PRM review not more than ten business day before the completion date of the contract.

9. Oral Presentation of Evaluation Findings and Recommendations: One final presentation shall be given to PRM in Washington, DC prior to the completion of the contract.

Expectations

1. The contractor shall maintain open, respectful, timely, and collaborative communications with PRM, resulting in a relationship that proactively addresses potential or current problems with flexible, workable, and appropriate solutions. It is a priority for PRM to be a good and supportive partner in this evaluation.

2. The contractor shall be responsive to PRM throughout the project and demonstrate ability to design an evaluation, analyze findings, and present results in line with the needs of the

bureau. When in doubt, the contractor shall reach out to discuss questions with PRM in a proactive and transparent way.

3. The contractor shall provide all documentation and reports to PRM for review and clearance; PRM will determine whether/when they will be disseminated to or shared with beneficiaries, UN agencies, NGOs, or other evaluation participants. This is for the purposes of ensuring a targeted, clear, and coherent evaluation approach and not to influence or change the data in any way.

4. The contractors shall coordinate with, and be responsive to, PRM in all aspects of project management and implementation. The contractor is expected to answer communication and submit agreed-upon deliverables on time.

5. The contractors shall forward all project deliverables to PRM according to the final timeline, barring unforeseen delays. When there are unforeseen delays, or other project or financial issues arise, the contractor must inform PRM immediately.

6. The contractor shall deliver high quality final products (deliverables) suitable for PRM purposes. The products shall be professional, well written, carefully proofread and tailored to influence and inform PRM-supported MHPSS initiatives and work. Other potential targets for the report include IOs, NGOs other donors/governments, etc. The final evaluation shall be considered a PRM product. PRM will decide who will receive the report and in what way.

Position Location and Hours

With the exception of the field-based data collection, project activity is anticipated to take place at the contractor's place of work. Data collection and analysis will take place in the United States, Geneva, and in the countries/regions of focus. Prior to the desk review, the evaluation team will visit PRM for consultations at State Department Annex (SA- 9) at 2025 E Street NW in Washington, DC, or meet virtually in the presence of COVID-19 restrictions. All relevant PRM documents required for the desk review will be provided to the contractor once the contract is issued.

Security Concerns

Contractors should be aware of changing security conditions in potential evaluation countries. The contractor should consider security limitations when selecting fieldwork countries.

Logistics Support

PRM will provide the contractor with access to relevant program and project documents, including those not in the public domain, such as IO and NGO reporting, strategies, etc., once the award has been issued. PRM will also provide the contractor with contact information of PRM (DC office and field) and partner staff as well as facilitate introductions, where needed. In addition, PRM will provide evaluation report and summary templates. All other support will not be of a logistics nature.

Other Information

The evaluation report and its findings are proprietary and are not to be made public or shared externally without the consent of PRM. PRM reserves the right to disseminate and circulate the evaluation report to colleagues (USG, international, and NGO partners), as determined appropriate. PRM may also choose to post the final report on the Department's internet site for further visibility. The contractor will be acknowledged in all circumstances.

General Task Order Terms and Conditions

Period of Performance

The period of performance shall begin on the effective date of the award. The total period of performance for this effort shall be ten months from the effective date of the award.

Place of Performance

The work to be performed under this task order will be performed at the Contractor's site.

Task Order Terms and Conditions

In addition to the terms and conditions specified in this task order, all terms and conditions of the Contractor's IDIQ Contract shall apply.

DOI-AAAP-0028 - Electronic Invoicing and Payment Requirements – Internet Payment Platform (IPP) (Apr 2013)

Payment requests must be submitted electronically through the U. S. Department of the Treasury's Invoice Processing Platform System (IPP).

"Payment request" means any request for contract financing payment or invoice payment by the Contractor. To constitute a proper invoice, the payment request must comply with the requirements identified in the applicable Prompt Payment clause included in the contract, or the clause 52.212-4 Contract Terms and Conditions - Commercial Items included in commercial item contracts. The IPP website address is: https://www.ipp.gov.

Under this task order, the following documents are required to be submitted as an attachment to the IPP invoice.

Supporting travel documentation

Invoices for travel must include the name of the traveler, travel itinerary, purpose of travel, receipts for airfare or other means of transportation, hotel, rental car, and any other expense over $75, and any other documentation requested by the Contracting Officer. **No travel is authorized unless prior government approval from the COR is obtained.**

- The contractor is responsible for ensuring invoices submitted are accurate and complete, and all labor, travel and other direct costs are in accordance with federal guidelines, the FAR Part 31 and other Government mandates and directives.
- Additional supporting documentation MAY BE REQUESTED at the discretion of the COR or CO.

Final Invoice

Within sixty calendar days of product acceptance and/or completion of services:

a. The contractor shall submit a final invoice, designated as such by a clear statement of "FINAL INVOICE" on the face of the invoice document.
b. The contractor shall provide a certificate of completion which certifies all goods and service have been provided as required by this task order.

The sixty calendar-day submission timeframe shall not be extended without written authorization from the contracting officer. In the event items a, b, or c above are not submitted within the authorized timeframe, the contracting officer will make final cost determinations in order to make final payment and closeout the task order unilaterally.

The Contractor must use the IPP website to register access and use IPP for submitting requests for payment. The Contractor Government Business Point of Contact (as listed in SAM) will receive enrollment instructions via email from the Federal Reserve Bank of Boston (FRBB) within 3 - 5 business days of the task order award date. Contractor assistance with enrollment can be obtained by contacting the IPP Production Helpdesk via email ippgroup@bos.frb.org or phone (866) 973-3131.

If the Contractor is unable to comply with the requirement to use IPP for submitting invoices for payment, the Contractor must submit a waiver request in writing to the Contracting Officer with its proposal or quotation.

(End of Local Clause)

Section 508 Compliance Requirements

The offeror shall ensure the personnel providing the labor hours possess the knowledge, skills, and ability necessary to address the applicable Revised 508 Standards defined in this task order, and shall provide supporting documentation upon request.

For Microsoft Office and PDF documents, the latest WCAG 2.0/2.1 Level A and AA Conformance test results must be based on the Harmonized Testing Guidance from the Accessible Electronic Document Community of Practice (AED ACOP).

Key Personnel Designation

For the purpose of the overall performance of this effort, the Senior or Mid-Level Evaluation Advisor or Evaluation Methods/Implementation Specialist and one Senior or Mid-Level Humanitarian Technical Advisor/Subject Matter Expert shall be designated as a key person. The individuals performing in key categories are considered by PRM to be essential to performance.

Quality Assurance

The COR will review, for completeness, preliminary or draft documentation that the Contractor submits, and may return it to the Contractor for correction. Absence of any comments by the COR will not relieve the Contractor of the responsibility for complying with the requirements of this work statement. Final approval and acceptance of documentation required herein shall be by letter of approval and acceptance by COR. The Contractor shall not construe any letter of acknowledgment of receipt material as a waiver of review, or as an acknowledgment that the material is in conformance with this work statement. Any approval given during preparation of the documentation, or approval for shipment shall not guarantee the final acceptance of the completed documentation.

Annex 4: Detailed Methodology

Data Collection Design and Implementation

The evaluation team conducted a mixed-methods evaluation with both quantitative data and qualitative data. Quantitative data collection methods included an online survey that was distributed to NGOs that have received DOS/PRM-funding for MHPSS programming. Qualitative data collection methods included in-person, online, or hybrid individual interviews or focus group discussions with service providers and service users.

Sampling

The survey data contextualized the interview data. The Evaluation Team tried to reach all the NGOs PRM funded between 2018 and 2021. Inevitably, there was a respondent bias.[21] The team used the initial consultations to validate the in-depth interview guides and survey questions. Of the 89 qualitative data collection events: 48 interviews were held with providers and 39 with service users. Unless recommended by the MHPSS providers, the service user FGDs were held separately with women and men and included 21 women and 14 men. The Team interviewed 48 NGOs and 37 IOs in Brussels, Geneva, Turkey, and Bangladesh. Three interviews were conducted with the local Bangladeshi community.

Limitations

The Evaluation Team could not ethically interview service users currently undergoing psychiatric or intensive psychological treatment. The MHPSS field also has a high rate of service

[21] The respondent bias, to some extent, reflects difficulty reaching MHPSS teams that had been funded earlier but PRM currently no longer funded. Some original team members were no longer working with the NGO, and a few programs may have disbanded. Given high rates of stress and reported secondary trauma in this field, particularly during COVID-19, there was also a high turnover in personnel and the current staff may not have wanted to report on events that happened prior to their time.

provider burnout and turnover. To ensure the safety of all, the team requested the IP MHPSS managers to select the interviewees and identify counselors to support interviewees if needed.

This selection process necessarily introduced a respondent bias. The Team gratefully appreciated service users' and providers' candidness and willingness to share their experiences and knowledge. After the Team introduced the evaluation purpose, most interviewees realized that they were not evaluating the individual NGO's or IO's programming but PRM's support for MHPSS worldwide. Most welcomed sharing experiences and advice and in several instances, used the FGDs to reflect with one another. Since this evaluation is designed to provide practical, achievable recommendations to inform PRM's future MHPSS strategy and programming, the interviewees' focus on how and why certain interventions worked, and others were less successful, proved to be informative and insightful.

Quantitative Data Collection

Quantitative data collection was conducted through an online survey that was designed to collect information about programming from across DOS/PRM's portfolio to deepen and validate the inception report portfolio review findings. It primarily consisted of close-ended questions, with a few open-ended responses included. The survey focused on approaches, interventions, and therapies used by different organizations in their MHPSS work; the populations and numbers of beneficiaries served; sector integration of services; the integration of beneficiary needs and perceptions in MHPSS work; changes and adaptations in response to the COVID-19 pandemic; program indicators; and the number of staff members and volunteers supporting this work. The survey collected information about each organization's programs, it was not designed to gather information about the perceptions or beliefs of the individuals who complete the survey. The online survey respondents were distributed to stakeholders from DOS/PRM-supported NGOs, including Project Managers, Refugee Coordinators, and Country Directors with a estimated sample of 75-100 NGOs. The respondent sample included a range of geographic DOS/PRM expertise and experience. Respondents also represented projects with varied MHPSS implementation strategies, including "standalone" and "integrated"

programming. For those representing projects with integrated program strategies, the evaluation team worked to ensure perspectives were included from a range of different integrated projects, such as protection, water, sanitation, and hygiene [WASH], nutrition, health, GBV, livelihoods, education, and reproductive health. The evaluation team administered the online survey from February to May 2022 and conducted analyses in June 2022. The analyses primarily consisted of summary statistics to give a broad understanding of DOS/PRM's programming and included some analyses of open-ended questions.

Qualitative Data Collection

Data collection occurred in Geneva and Brussels during early February 2022, in Turkey for a period of approximately two weeks in mid-March 2022, and for two weeks in Bangladesh during early April 2022. In Turkey, five sites were covered during the data collection phase: Ankara, Gaziantep, Sanliurfa, Izmir, and Istanbul, whereas two sites were covered in Bangladesh: Dhaka and Cox's Bazar.

Three evaluation team members conducted the fieldwork in Turkey and two members conducted the interviews in Geneva. In Brussels and Bangladesh, where COVID-19 restrictions and a new variant prevented a second member from going directly, one member conducted the in-person interviews. In Brussels, the Evaluation Team Lead conducted interviews with PRM, IOM, and IMC. In Bangladesh, the EnCompass MEL Specialist conducted in-person interviews. The Evaluation Team Lead and the MEL Specialist met online daily to review and discuss the interviews. The interviews held in Cox Bazar and Dhaka involved a hybrid approach: the Evaluation Team Lead participated online and the MEL Specialist in person. Although the logistics were challenging, the Evaluation Team was able to voice record most of the interviews for coding and summary analyses by other Evaluation Team members so that all had access to the methodologies employed.

Team members conducted all individual interviews and FGDs with service users in person. They conducted the consultations and a few staff interviews and FGDs online and organized hybrid interviews with service providers and managers in Bangladesh. The Evaluation Team conducting

data collection in Turkey and Bangladesh engaged one or more interpreters identified by each organization. Each organization also provided MHPSS services to service users with a psychologist or counselor on call should the interviewees require any support. To prepare for the visits, the team conducted orientation phone calls with relevant points of contact at the U.S. embassy and with NGOs and IOs. These calls helped the Evaluation Team generate a list of in-country stakeholders to speak with. All interview lists were validated with PRM prior to the country visits. Data collection included KIIs and FGDs with grantees, sub-grantees, service users, embassy staff, NGOs, IOs, and other allies and stakeholders. Following data collection, the Team analyzed the data in two Data Analysis, Integration, and Synthesis Sessions.

Ethical Considerations

The Evaluation Team developed an Informed Consent Form (ICF) that was shared in advance with organizations and interviewees to address any concerns. This advance planning allowed organizations to select service users who would not be negatively affected by participating in an interview about the MHPSS services they had received. The organizations also selected the translators and identified a psychologist or counselor on call should anyone require support prior, during, or after the interview process. During the interviews, key information from the ICF regarding privacy, confidentiality, anonymity, rights to pause or leave the interview at any time, was reviewed with the participants. Verbal consent was obtained by all participants and in most cases, permission to voice record was also obtained. The voice recordings were used for transcription purposes only. The teams made every effort to ensure that interview questions focused on the service users' observations and recommendations about how best to improve MHPSS programming. This evaluation was approved by the EnCompass IRB (IRB no. EC-001-2022).

Country Case Study Selection Criteria

In consultation with PRM, the EnCompass Evaluation Team prepared a matrix of countries (refer to Table 4) considering the following factors:

1. Sites where several MHPSS programs are operating and accessible
2. Regional/geographic diversity
3. Type and length of emergencies—onset, protracted, complex, etc.
4. Diversity in types of service users (refugees, IDPs, asylum seekers, etc.) and settlements
5. Urban settlements versus camp settings
6. Feasibility (logistics, COVID-19 travel restrictions)
7. Security, threat levels, and access

Table 4: Countries considered for the PRM evaluation by various factors

Country	Refugees*	IDPs*	NGOs	Security	COVID	Year begun	Urban/Camp	Nationalities
Bangladesh	880,000	427,000	TdH, IRC, HI	caution	ok	2017	camp/urban	Rohingya
Colombia	277	7,671,124	Malteser, SCF	threat	red	2015	urban	Venezuelan
Ecuador	70,000	490	JRS, HAIS	safe	red	2018	urban	Venezuelan
Jordan	1,300,000	140 (new)	IMC, CVT	caution	ok	2011	urban/camp	Syrians
Kenya	525,000	190,000	CVT, HAIS, JRS	caution	ok	2007	urban/camp	Somali, South Sudan
South Sudan	4,300,000		JRS, IMC	threat	not rated	2013	camps/sites	South Sudanese
Thailand	91,479	41,000	OHI	safe	ok	1984	camp/urban	Myanmar
Turkey	3,600,000	1,099,000	ASAM, SAMS, MUDEM, DOTW, others	caution	ok	2016	urban/camp	Syrians, Afghans, Iraqi, Iranians, etc.

* These data are derived from online sources (NRC for the IDPs)

The Evaluation Team presented an earlier version of this matrix to PRM and discussed the possible sites with PRM, the IOs, and NGOs. Based on the above considerations and current programming, PRM/Washington, D.C., in consultation with regional Refugee Coordinators and Program Managers, recommended Colombia and Turkey with Bangladesh as an alternate.

The UNHCR MHPSS advisor pointed out that both Turkey and Colombia are middle income countries, whereas large numbers of refugees and IDPs are currently hosted in low-income countries. Given concerns about a new COVID-19 variant, political volatility, and security risks (kidnapping for ransom and terrorist threats) in Colombia, the Evaluation Team in consultation with PRM, eventually chose Bangladesh for the second fieldwork site.

COVID-19 Safety Considerations

The Evaluation Team continuously monitored security and COVID-19 considerations in both countries. The Evaluation Team data collectors and translators proceeded with all necessary precautions to protect the team, participants, and other community members from the spread of COVID-19. Precautions included:

- Daily antigen tests for interviewers.
- Scheduling and organizing meetings with appropriate spacing in small groups, and when possible, outside. When inside, windows were kept open during group discussions.
- Participants, interviewers, and translators wore N95, FFP2, or double (clean) cloth masks at all times throughout the interview process. Participants were provided with a new, clean mask if they did not have one.
- The Evaluation Team and translators were fully vaccinated and wore masks during data collection. The team also sanitized equipment regularly and had hand sanitizer available for interviewees.

Sample

Online Survey

The evaluation team disseminated the online survey via SurveyMonkey to a purposive sample of DOS/PRM-supported NGOs. The sample was determined through a portfolio review and evaluation of the total population in consultation with DOS/PRM and IO and NGO stakeholders. The survey was distributed to organizations that administered programs in the following countries: Afghanistan, Bangladesh, Brazil, Cameroon, Chad, Colombia, Democratic Republic of Congo, Egypt, Ethiopia, Ira, Jordan, Kenya, Malaysia, Mauritania, Nigeria, Pakistan, Peru, South Africa, South Sudan, Tanzania, Thailand, Turkey, Uganda, and Venezuela.

To maximize anonymity, the survey did not collect demographic data about the person completing the survey and did not collect data on the organization's name. Since multiple organizations work within the countries where the survey was implemented, it will not be possible to determine which organization provided which response. While the evaluation team asked that each organization submit only one response per country, not all individuals who received the survey were able to answer every question. Therefore, during recruitment the evaluation team shared the information being requested and provided suggestions of who the participant may want to consult and/or forward the survey to in order to provide the information necessary.

The online survey respondents were distributed to stakeholders from DOS/PRM-supported NGOs, including Project Managers, Refugee Coordinators, and Country Directors with an estimated sample of 75-100 NGOs. The respondent sample included a range of geographic DOS/PRM expertise and experience. Respondents also represented projects with varied MHPSS implementation strategies, including "standalone" and "integrated" programming. For those representing projects with integrated program strategies, the evaluation team worked to ensure perspectives were included from a range of different integrated projects, such as protection, water, sanitation, and hygiene [WASH], nutrition, health, S/GBV, livelihoods, education, and reproductive health.

A total of 43 NGOs responded to the online survey from 14 countries, with Turkey NGOs responding the most (25 percent). 20 percent of responses came from Jordan, and 9 percent of responses came from Bangladesh. Asian countries were heavily respresented in the survey data, however we received less responses from Africa, South America, and other regions.

KIIs and FGDs

Data collection for the case study included individual interviews and FGDs with staff members and service users of PRM-funded MHPSS organizations implemented by IOs and NGOs operating in Turkey and Bangladesh. Additionally, the sample included key staff members of PRM based in each case, including Refugee Coordinators (RefCoords), RefCoords support staff, and relevant Program Officers. The Evaluation Team conducted one interview with PRM staff in each country.

Staff members at IOs and NGOs included those who can speak to the organizations' MHPSS work and, in some instances, included the country manager (if the organization was international), program managers for PRM-funded MHPSS programs, and other staff members or volunteer implementers. These other staff members included MHPSS counselors, therapists, trainers, researchers, M&E staff as relevant for each organization. For the most part, all interviews with a particular organizations' staff and beneficiaries occurred in the same site, identified by the organization based on where the majority of their PRM-funded MHPSS programming occurred, unless the organization indicated that it made sense to speak with people in multiple sites. This occurred, for example, when an organization's country manager was located in the capitol, but programming occurred in another location.

The Evaluation Team interviewed an average of four to eight staff members per IO and NGO in each country. These interviews occurred either as individual or small group interviews depending on the availability, geographic distribution, and preferences of the staff members. For service users, the Evaluation Team conducted two or more interviews (either in groups of four to eight people or individuals) at almost all IOs and NGOs. Whether to conduct individual or group interviews with service users was determined by the IO or NGO staff based on the

needs of their service users. Some IOs and NGOs flagged that it would not be possible to speak to PoCs due to security reasons. In those cases, PoCs were dropped from the sample of that IO and NGO.

Within each country, the IOs and NGOs served similar PoCs, either at different locations within the country or in the same location but with somewhat different services. In Turkey, the PoCs primarily consisted of Syrian refugees, but also included refugees from Iran, Iraq, and Afghanistan. In Bangladesh, the PoCs were primarily Rohingya persons from the Rakhine State of Myanmar.

The Evaluation Team sampled NGO and IO respondents using a snowball process, in which participants identified the next wave of potential participants using purposive criteria (but generally would not be identifying the same types of respondents as themselves). For example, the PRM RefCoord identified and supported outreach to IO and NGO program managers, who supported identification and outreach to other relevant staff within their organizations. A total of 89 data collection events occurred in Bangladesh, Brussels, Geneva, and Turkey with NGOs, IOs, USG, and service users and various organizational levels.

Sample of the qualitative interviews conducted in Bangladesh, Brussels, Geneva, and Turkey (Total: 89 qualitative sessions)

Table 5: Interviews by location.

Location (n=89)	Number (percent)
Brussels	3 (3 percent)
Geneva	4 (4 percent)
Turkey	46 (52 percent)
Bangladesh	36 (40 percent)

Table 6: Interviews by stakeholder group.

Stakeholder Group (n=89)	Number (percent)
IO	37 (42 percent)
NGO	48 (54 percent)
USG	4 (6 percent)

Table 7: Interviews by service provider organization level.

Service Provider Organization Level (n=48)	Number (percent)
HQ	7 (15 percent)
In-country HQ	21 (44 percent)
Frontline	20 (42 percent)

Table 8: Interviews by service users.

Service Users (n=39)	Number (percent)
Male	14 (36 percent)
Female	21 (54 percent)
Mixed	4 (10 percent)

Recruitment

As with the sampling approach, the Evaluation Team relied on contacts within PRM and the IOs and NGOs to support initial contact with other staff members and grantees for recruitment. The Evaluation Team asked for support from PRM and relevant IO and NGO representatives to connect potential participants with the Evaluation Team. However, the Evaluation Team did not confirm who participated from the sampled potential respondents and the final sample of

participating respondents with PRM, IOs, NGOs, or others at any time before, during, or after data collection.

Recruitment process for the Online Survey

DOS/PRM provided the contact information for a lead person for each country team at each organization sampled. This information was saved in a secure Excel tracker and was used to contact participants. The Project Coordinator on the evaluation team was responsible for maintaining the secure Excel tracker to document email correspondence with the participants. The Project Coordinator also communicated with the participants through e-mail.

The survey may require the participant to consult with other people within their organization to respond fully, therefore, this was outlined in the e-mail to respondents. The survey was estimated to take approximately 30 to 45 minutes to complete.

The Project Coordinator kept the Evaluation Team Lead copied and apprised of any communication and questions from invited respondents about the survey. The team sent email reminders to complete the survey, according to the data collection schedule.

Recruitment process for PRM staff

As noted above, PRM in Washington, D.C. connected the Evaluation Team with a PRM RefCoord in each country in order to coordinate planning for data collection. These RefCoords are familiar with PRM's MHPSS work in their respective country and were sampled to participate in an interview in addition to the support they provided in coordinating contacts for the evaluation. The RefCoords also made introductions between the Evaluation Team and relevant PRM staff in each country, such as the program officers and Humanitarian Affairs Team. The RefCoords made these introductions over e-mail prior to the Evaluation Team travelling to each country so that the team could organize and schedule interviews with IO and NGO staff who are willing and available to participate. The team then removed the RefCoord from the email chain in order to plan for a date, time, and location (either in-person or virtual) for the interview if the participant(s) showed interest.

During the recruitment process, the Evaluation Team maintained an interview tracker stored in a password-protected folder on the EnCompass SharePoint site for this project. Only Evaluation Team members had access to this file, which included the name of the contact, their organization, e-mail address, and title, as well as information on when they were contacted, whether they agree to an interview, and, if so the timing and location of their interview as well as a record that they have received the ICF. The tracker also maintained which respondents provided informed consent verbally and consent to voice record was obtained. This tracker was used for staff from PRM and the IOs and NGOs but did not contain service user information.

Recruitment process for IO and NGO staff and volunteer implementers

The recruitment process for IO and NGO staff members and volunteer implementors was similar to the recruitment process for PRM staff. In most cases, the PRM RefCoord connected the Evaluation Team with a point of contact within the IOs and NGOs over email. Depending on this point of contact's role in the organization, the Evaluation Team recruited them, or worked with them in order to identify contacts to interview. As with PRM staff, the evaluation team coordinated with the IO and NGO contacts over email prior to arrival in each country in order to schedule interviews with interested participants. This process was tracked using the same interview tracker that was used for PRM staff.

Recruitment process for Service Users

In order to access the service user populations, the evaluation team relied on each IO and NGO to identify participants. Based on the sampling criteria outlined above, and the determination whether to conduct FGDs or KIIs, the IOs and NGOs informed potential participants about the study and let them know the eligibility criteria to participate if interested. In communications with IOs and NGOs, the evaluation team emphasized the importance of voluntary participation to PoCs. Staff informed service users of the date, time, and location of data collection. The evaluation team only interviewed PoCs who determined that they are interested and came to the data collection location at the data and time described. A separate tab on the interview

tracker recorded the dates and times of interviews with service users. However, PoC names and contact information were not collected or recorded at any point in order to minimize the risks of a data breach.

As noted above, the Evaluation Team worked with each IO and NGO to determine whether their population of service users is more comfortable in group or individual interview settings. If in an FGD, the groups will be homogeneous by sex (and age when relevant). There were four instances where both sexes were interviewed together in an FGD due to time constraints or suggestions from the IO or NGO staff.

Data Collection Procedures

The following section outlines the process for piloting tools, obtaining informed consent, and gathering data during data collection for the case study. The online survey was conducted in English, whereas all interview tools and consent materials were translated into the relevant languages prior to the start of data collection. In Turkey, the languages included Arabic, Iranian Farsi, Afghani Farsi, and Turkish. In Bangladesh, the languages included Rohingya and Bangla.

Updating the Data Collection Tools

Prior to data collection, the Evaluation Team requested input and recommendations from the PRM RefCoord on all the data collection tools to be used in each country in order to provide feedback based on their knowledge of PRM programming in each country. They reviewed:

- Interview length
- Clarity of content and questions
- Extent to which questions were appropriate and relevant or appropriate in terms of cultural sensitivity and relevance
- Sequence of questions

The evaluation team reviewed the RefCoords' suggestions and updated the tools accordingly prior to conducting interviews with IOs, NGOs, and service users.

The Evaluation Team also asked the IOs and NGOs whose service users are participating in the study to review data collection tools to be used with service users for implications of word choice, potential triggers, and manifestations of trauma. The IO and NGO staff reviewed the text of the questions in English. For the online survey tool, the evaluation team piloted the tool with two NGOs to ensure the survey would achieve its purpose. Feedback from the NGO staff was incorporated into the final version of the survey (Annex 5).

Informed Consent Processes

Prior to completing the online survey, survey respondents were prompted to provide consent to participate. The language introducing the online survey explained the:

- Intent of the evaluation
- Type of data collection
- Procedures and duration
- Voluntary nature of participation and right to withdraw at any time
- Risks, benefits, and compensation/incentives
- Confidentiality
- Data management and security procedures
- Who to contact for questions and concerns

Skip logic in the online survey prevented participants from continuing with the survey if the appropriate consent checkbox was not selected. By checking the consent checkbox and completing questions throughout the survey, the respondent provided consent to participate.

The evaluation team provided participants with background information about the evaluation and contact information for the Team Lead, Evaluation Specialist, and EnCompass IRB Manager, who participants can contact to answer additional questions or handle any concerns.

Before the start of each qualitative data collection event, the data collector obtained informed consent from the potential respondent(s). Prior to starting the KII or FGD, the data collector provided each respondent with a copy of the consent form. For respondents with access to email, the consent form was provided via email prior to data collection. For those who did not have access to email, the data collector provided a physical copy for them to review immediately prior to data collection. The consent form was provided in English or the relevant language for the population, depending on the participants. The consent form explained the:

- Intent of the evaluation
- Type of data collection
- Procedures and duration
- Voluntary nature of participation and right to withdraw at any time
- For FGDs: Expectations to and from fellow participants
- Risks, benefits, and compensation/incentives
- Confidentiality
- Data management and security procedures
- Audio recording information
- Whom to contact for questions and concerns

Prior to beginning the interview, the data collector summarized the informed consent form with each respondent and ensured that the respondent had time to ask questions about the

evaluation or the consent process. For FGDs, the Evaluation Team provided the opportunity for each person to ask questions individually if desired.

If the respondent agreed to participate, they provided verbal consent. Participants were not asked to sign the consent form in order to minimize the potential for a form to be lost and create a potential breach of privacy. Instead, the data collector checked the corresponding box indicating the respondent's response and initialed the corresponding line to provide a record of consent. The data collector also requested permission to capture an audio recording of the interview onto a local offline audio recording device. If the participant agreed, the data collector recorded the interview. If the participant did not consent to being voice recorded, the interview proceeded without voice recording and only verbatim notes were taken. The data collector captured consent via audio recording when possible and with the respondent's consent. The data collector also recorded consent using the informed consent tracker. In this tracker, the data collector included the participant ID, whether the participant consented to the interview, whether permission was obtained to voice record, and the data collector's initials to confirm that consent was obtained. The Evaluation Team saved the initial consent forms and the consent tracker on the secure project SharePoint site.

The Evaluation Team also provided participants with a copy of an information sheet that described the evaluation, what they agreed to as participants, and the Evaluation Team Lead's contact information. Informed consent forms for PRM, IO, and NGO staff were written at the 12th grade level due to the education requirements to receive those positions. Informed consent forms for service users were written at the 5th grade level to account for the wider range of educational attainment among service users.

Procedures

This section outlines data collection procedures for all groups of respondents. COVID-19 considerations for all respondent types are included at the end of the section. The evaluation tools can be found in Annex 5.

Procedures for the Online Survey

The online survey tool did not collect personally identifying information from participants, nor did it ask for the respondent's organization. The survey collected information on which PRM country program the participant was responding about. The evaluation team monitored the response rate in SurveyMonkey.

Procedures for PRM, IO, and NGO Staff

Interviews with PRM, IO, and NGO staff occurred in-person or virtually, depending on the preferences and availability of the staff members and the COVID-19 situation at the time of data collection. These interviews either occurred at the participants' office or in secure locations outside or a similar location, depending on the participants' preference. If outdoors, the Evaluation Team and participant identified a location where they were unlikely to be overheard and would stop the interview if someone approached them and until that person left. The interviews lasted 60 to 90 minutes. The Evaluation Team asked respondents to reaffirm consent at regular intervals and informed the participants as they reached the end of the allotted time.

Most respondents in these categories were fluent English speakers. As such, most interviews with these groups were conducted in English. When necessary, the Evaluation Team engaged a translator to support these interviews. In Turkey, this was generally Turkish, though some respondents required an Arabic translator. In Bangladesh, this was Bangla. The Evaluation Team worked with the IOs and NGOs to identify a suitable translator.

At the conclusion of the interviews, the data collectors uploaded the audio recording, following the proper data management steps to save and upload the audio recording to the SharePoint site. The evaluation team member who conducted the interview or acted as notetaker completed a transcript of the interview based on the interview notes and the audio recording. A transcription company was hired to transcribe the voice recordings and clean the notes.

This participant group did not experience intense emotional distress during data collection. However, prior to data collection, the Evaluation Team identified MHPSS counselors to support staff who experienced emotional distress and referred other respondents to these counselors on an as-needed basis.

Procedures for Service Users

Due to limited digital literacy and access among PoCs, all data collection with service users was in person. Both individual and group interviews occurred at a location recommended by the IO and NGO that worked with the service users. In Turkey, this location was mostly where programming occurred so that service users felt comfortable and safe. In Bangladesh, this location varied depending on the NGO or IO staff recommendations. In some cases, interviews occurred in the camps at community centers and, in other cases, interviews occurred at health static points, primary health centers, or health points. In cases where the interviews occurred outside, the Evaluation Team and participant identified a location where they would not be likely overheard, and stopped the interview if someone approached that person. The interviews lasted 60 to 90 minutes. The Evaluation Team asked the respondent(s) to reaffirm consent at regular intervals and informed the participant as they reached the end of the allotted time. To the extent possible, male and female data collectors present (in Turkey), the data collectors remained the same sex as the interviewees. Only in Bangladesh was this option not possible since only one female data collector was present in-country.

In Turkey, the preferred language for beneficiaries varied, and included Arabic (the majority), Turkish, Kurdish, Dari, or Farsi. In Bangladesh, the preferred language for service users was most commonly Rohingya. The evaluation team worked with the IOs and NGOs to identify an appropriate translator and provided guidance on ethics at the beginning of data collection. All interview tools and consent materials were translated in the relevant languages prior to the start of data collection. The translated tools were shared with the translators as a physical copy.

At the conclusion of the interview, the data collectors uploaded the audio recording, following the appropriate data management steps to save and upload the audio recording to the

SharePoint site. The evaluation team member who conducted the interview or acted as notetaker completed a transcript of the interview based on the interview notes and the audio recording of the translator's real-time English translation. A transcription company was hired to transcribe the voice recordings and clean the notes.

The evaluation tools for service users were designed to allow participants an affirming space to highlight positive experiences of the MHPSS program and did not explicitly ask about traumatic experiences. However, all service users of the programs being evaluated are service users due to having faced traumatic experiences related to war and displacement; therefore, participants experienced some emotional distress when discussing the program. As such, the data collection team ensured that an MHPSS counsellor affiliated with the IO or NGO who implemented programming was close by during the interview. This was a staff member of the IO or NGO who provided these services professionally for service users. Depending on the preference of the service users, the counselor joined the interview if participant experienced difficulties, or the participants requested the counselor to be a part of the interview prior to the session. The Evaluation Team also developed a referral sheet in collaboration with the IOs and NGOs prior to the data collection that could be provided to the participants should they disclose a traumatic experience. The referral sheet included the following contact information:

- Domestic abuse/sexual violence
- Medical/psychosocial needs
- Advocacy groups
- Other support organizations, depending on the context.

The interviewers and data collectors did not take any photographs during data collection and no photos will be used for research purposes. However, in some instances, service users of these programs asked to take a photo of the group, including the interviewers, using their own phones. These photos were important and meaningful for people who have lost most or all of their personal objects. These photos help service users reconstruct their own life histories.

When this happened, the Evaluation Team ensured the wishes of all participants were honored and asked politely that any participants who wish to take photos hold off until after the interview and then ask for the participants' verbal consent first. The Evaluation Team reminded everyone that people may choose not to have any photos taken and their wishes must be respected and ensure that only participants who consent to be photographed by another participant are included in photographs. The Evaluation Team did not play any other role in photography conducted by participants.

In case of adverse events and incidents (for all respondents):

The Evaluation Team used an Incident Report Form to document and respond to any security-related incidents. In any case where there was an adverse consequence to humans participating in the research, the details would be reported according to the instructions outlined in an Adverse Event Form. The process for reporting adverse events and incidents is outlined below:

- If any adverse event occurs that may threaten the emotional or physical safety or well-being of the respondent, the Evaluation Team will complete the Adverse Events Form. "Adverse events" refers to any threat to participant safety and well-being, including the early conclusion of an interview because of emotional or psychological incidents or re-traumatization. Any adverse event must include a full description using the Adverse Event Form and should be submitted immediately to the EnCompass IRB and communicated to the PRM team. Respondents experiencing an adverse event will be provided with or connected to relevant support.

- If any incidents occur that may threaten the confidentiality or security of the respondent or a member of the data collection team, the Evaluation Team will complete the Incident Report Form and notify the EnCompass IT Team, EnCompass IRB, and PRM as soon as possible.

- If an incident or adverse event takes place during data collection, data collection efforts will be halted until the EnCompass IRB investigates and makes a determination about the best course of action. Data collection may not resume until the EnCompass IRB gives approval in writing.

Data Security

All evaluation activities prioritized the individual protection of participants and stakeholders. All data were kept at EnCompass, and only voice recordings with no personal identifying information were shared with a transcription company to transcribe the interviews.

This section outlines detailed data security protocols. The Evaluation Team reviewed and revised them as needed throughout the evaluation period. The following approaches helped the evaluation team employ the highest level of data security and mitigate risk:

- Only essential personnel of EnCompass LLC who are involved in the evaluation handled sensitive programmatic information.

- The evaluation team used an encrypted folder on the EnCompass server to store all data; after each primary data collection event (e.g., interview, meeting, survey collected), a team member transferred this file directly to the secure folder for data storage after ensuring data were de-identified.

- When data was analyzed, a member of the Evaluation Team transferred the data from the secure server directly onto a secure data analysis platform, Dedoose, an online qualitative data analysis software package.

- The Evaluation Team scrubbed transcripts or other personally identifying information immediately after data collection before it was transferred to secure storage. Data was encrypted both in transit and at rest, ensuring all information remained confidential.

- Data collectors did not collect personal information during data collection, except for in a secure tracker stored in a separate part of the file structure from the data.

- The evaluation team and any essential personnel tasked with anonymizing data stripped the data of identifying information and stored respondents' information in separate files when coding qualitative and quantitative data.

- The evaluation team used end-to-end encrypted software (Dedoose) for all coding. Only members of the evaluation team had access to this information.

- The Evaluation Team stored all deliverables and evaluation materials on an encrypted local server.

- At the conclusion of the evaluation, EnCompass ensured that all information was centralized in the encrypted server, then restricted access to this folder to a single EnCompass point of contact. No other EnCompass staff or independent consultants who worked on this project were able to access this folder at any point after the close of the evaluation. The dataset will be retained for three years, as agreed upon with PRM. If further data disposal measures are necessary, the evaluation team will develop such measures in consultation with PRM. Any physical data retained will be shredded according to industry standards.

- EnCompass will store all data securely and will maintain respondents' anonymity in compliance with the approved protocol.

- All evaluation activities will prioritize the individual protection of participants and stakeholders. All data will be stored at EnCompass. The Evaluation Team reviewed and revised these detailed security protocols as needed throughout the evaluation period.

The EnCompass Project Coordinator was responsible for transferring online survey data from SurveyMonkey to the secure server. Online survey data was stored in one Excel sheet, located on the SharePoint site. This sheet did not contain any personal identifying information. The

evaluation team maintained a separate Excel sheet that tracked the contact names and email addresses to which the online survey had been sent. This tracker was stored on the SharePoint site and updated by the Project Coordinator throughout the open survey period. The evaluation team shared a survey link through e-mail to all the respondents, requesting them to participate in the survey. The team assigned survey responses a unique code number and analyzed them in Excel.

Personal information from KIIs and FGDs were only recorded in a secure, encrypted KII and FGD tracker. This tracker included transcripts that linked to de-identified data sources and codes. Each KII and FGD respondent(s) were assigned a unique code number, which data collectors used to label corresponding transcripts, audio recordings, and informed consent forms. Each data collector was responsible for properly labeling each transcript, completing the shared tracker, and scrubbing each transcript produced of personally identifying information.

The tracker connecting staff respondent names to the unique number were kept in an encrypted file and only the data collectors in this study were able to view the list. This tracker, along with all data, will be moved offline at the end of the evaluation, and will be destroyed three years after the end of the contract.

Data collectors retained any written notes in their personal possession until they were able to type their notes and transcribe the interviews. They saved audio recordings on the project SharePoint site. Transcriptions were saved on the project SharePoint site and data collectors used the transcription template designed. After entering handwritten notes into the designated section in the relevant transcript file, data collectors destroyed the handwritten notes. Data collectors directly recorded typed notes into the transcription template saved on the SharePoint site, and stored them on the SharePoint site. Evaluation Team members did not store local copies of evaluation-related files on their computer at any point during this evaluation.

Data Analysis

The evaluation team transferred online survey data from SurveyMonkey to an Excel sheet stored on the secure SharePoint site. The team analyzed all survey data in the Excel sheet. The analyses included frequencies, summary statistics, and, where relevant, cross-tabulations and/or correlations. These data were entered into Excel to produce charts and graphs. Information about respondents were provided and stored separately to ensure anonymity and confidentiality.

The Evaluation Team analyzed the qualitative data in Dedoose. These data addressed key concepts, recurring themes, and significant (in the qualitative sense) outliers. Narratives, profiles, and quotes were anonymous unless there was a specific request to share this information. Even in such cases, the team will consider whether adherence to “Do No Harm” can be assured.

- The Evaluation Team completed all FGD and KII transcripts as Word documents. All data was stored securely, backed up, and maintained anonymity of respondents.

- The evaluation team coded and analyzed clean, redacted KII and FGD transcripts in Dedoose. Dedoose stores data using AES-256 bit encryption on Microsoft Azure servers. When transcripts were ready for analysis, a member of the evaluation team transferred them from the secure server directly into Dedoose.

All qualitative data from the interviews and the quantitative data from the surveys were analyzed separately and then jointly through a Data Collection and Interpretation Sessions (DAIS) conducted internally by the evaluation team.

Anticipated Limitations and Mitigation Strategies

As with all data collection efforts, this evaluation had particular risks and limitations. The limitations particular to this evaluation and how the team mitigated these effects are outlined below.

Selection bias due to purposive sampling

As with all purposive sampling approaches, there is some degree of bias that affects the selection of interviewees. This applies both to our purposive sampling methods in data collection and the selection of the two country case studies as a sample of the wider PRM portfolio. The case study selection was limited by the security and accessibility challenges present in some countries. In-country data collection was more feasible and accessible in some contexts. Findings and interpretations emerging from data collection in the two country case studies may not be representative of the entire PRM portfolio, a caveat the team should keep in mind throughout data analysis and reporting.

The Evaluation Team also recognized the tradeoffs between using highly participatory approaches to promote trust, insider perspectives, and an expanded network and the possibility of selection bias, particularly of beneficiaries. The evaluation team was cognizant of this bias when analyzing data.

The online survey was also purposively sampled; however, it included a much broader range of programs. The survey was sent to a purposively selected sample of NGOs and multilateral donors funded by DOC/PRM to work on MHPSS issues in particular countries between 2018 and 2020 (this includes some organizations whose funding period either began before or continues after this period). This sample excluded DOS/PRM grantee organizations who may be working on issues related to MHPSS but who do not have a formal MHPSS focus. This means that some best practices and learning from other grantee organizations may be lost. However, the survey focused data collection on grantee organizations in countries that DOS/PRM prioritized for MHPSS work and reduced the research burden on grantee organizations whose work is less relevant to DOS/PRM's goals in this evaluation.

Availability and willingness of key stakeholders

Access to key stakeholders, including service users who provided crucial information to address evaluation questions, was challenging at times. Lack of trust on the part of the stakeholders or

security conditions that arise in the sensitive contexts of IDPs and refugee camps and communities may have limited access. Respondents across countries may be reticent to speak with outsiders about the details of their work or involvement. To facilitate access, the Evaluation Team collaborated closely with PRM and relevant IOs and NGOs to establish trust with stakeholder groups, participants, and service users. For FGDs, the Evaluation Team worked with trusted IOs and NGOs to select groups of respondents in ways that prioritized comfort through groupings based on sex, age, and other factors relevant to minimize potential risks. Other security measures, including trauma-informed data collection approaches, data security, and comprehensive consent statements in an accessible language also helped mitigate these challenges.

Recall bias

Some of the data collection tools asked respondents about past events. There is a possibility of recall bias—the respondents may not remember previous events or experiences or omit details. In relevant cases, the Evaluation Team tried to mitigate recall bias by identifying respondents with extensive engagement with the relevant programming, or who participated regularly in applicable MHPSS activities.

Response bias

Response bias or social desirability bias, was, at times, challenging for this study. Response bias occurs when respondents feel pressure to give answers that are socially acceptable, or that they believe may be viewed favorably by PRM or implementing organizations. The design of this evaluation with participatory approaches helped mitigate the potential for response bias because a comfortable and secure interview environment should have facilitated responses that were as candid as possible under the circumstances. Trauma-informed strategies for data collection also helped elicit honest information and opinions from the respondents. The data collection tools also included carefully worded questions to ensure respondents did not feel there was a “right” or “socially desirable” answer to questions or probes. Both recall and

response biases were mitigated through triangulation of responses with other data sources. Lastly, the team had data security protocols, outlined in the Data Collection Guide, that reassured respondents of their anonymity and safety.

Security considerations

EnCompass data collection protocols and processes prioritized safety and well-being of potential participants, local communities, and EnCompass staff and representatives. The Evaluation Team continued to monitor security considerations in each case study context, including local security considerations in regions and cities intended for travel. The Evaluation Team had continued discussions with PRM about the feasibility and safety of data collection in each context and made adjustments as required.

Unanticipated contextual changes because of the COVID-19 pandemic

The Evaluation Team understands that the human rights documentation context in which participants are working could shift during the COVID-19 pandemic, and information gathered that characterizes the landscape and community of documentation actors may be affected by this shift. The team designed data collection tools in a way that clarified distinctions between long-term; action-forcing; and pandemic-related documentation practices and coordination.

Other challenges related to the COVID-19 pandemic

The COVID-19 crisis had severely curtailed international and domestic travel, however, restrictions and changes to travel guidelines across different countries do not hinder plans to conduct in-country data collection. The Evaluation Team continued to carefully assess the COVID-19 situation in each data collection country and adjusted plans as needed. The Evaluation Team integrated sanitation practices and protocols regarding COVID-19 vaccinations and tests as stated above.

Further Ethical Considerations

Data collection did not commence until the EnCompass IRB conducted a full review and approval of the design and data collection instruments. The Evaluation Team did not seek in-country IRB review in Turkey and Bangladesh because of the limited numbers of IRBs that review social scientific research in either country. The Evaluation Team integrated the following ethical considerations throughout the evaluation design and implementation.

Trauma-Informed Data Collection

The Evaluation Team followed guidelines that prioritized data collectors' and respondents' safety and well-being to ensure high-quality, comprehensive, and accurate data. The Evaluation Team had integrated trauma-informed considerations into the design of data collection tools and methods presented in this data collection guide. These approaches reflected the evaluation's overall ethics and safety methods, augmented with specific trauma-informed approaches to meet the highest ethical standards. For this data collection, the Evaluation Team was closely collaborating with relevant IOs, NGOs, and RefCoords to tailor the application of these approaches to the sensitive circumstances of MHPSS issues in each relevant context and continued to iteratively evaluate and respond to risks throughout the evaluation. The Evaluation Team especially prioritized minimizing risks that could result in participant re-traumatization. The team also ensured data collection considered subject matter and context sensitivities, promoted respondents' ownership of the process, and empowered them to tell their stories and perspectives and maintain a firm sense of authorship over their representations.

Trauma-informed methods integrate the following approaches into data collection:

- *Ensuring physical and emotional safety* – Prioritizing physical and emotional safety and welfare of participants and data collectors, minimizing risks of re-traumatization and secondary trauma

- *Honoring and affirming participants' choices* – Building on and expanding from informed consent, taking actions to ensure participants are empowered to make their own choices about participation at every step

- *Building collaboration into data collection* – Using strengths-based and participatory approaches to provide participants with opportunities to be involved in data collection processes to the degree to which they are comfortable and in ways with which they are comfortable

- *Establishing and maintaining trust* – Prioritizing establishing and maintaining trust between the Evaluation Team and participants, fostered by introductions facilitated by trusted AAP representatives, PRM, or other human rights stakeholders during snowball sampling

- *Prioritizing empowerment* – Ensuring participants feel validated and affirmed at each interaction with the Evaluation Team, being careful to avoid exercises that may feel extractive

Confidentiality

The data collection team informed each participant that no data presented or quoted will be directly attributable to them individually by name or by organization. The survey has been designed such that even the evaluation team would not be able to determine which organizations responded. In the interviews, data collectors made no reference to any names or anything heard in a prior interview, even with members of the same organization. Interview notes, recordings, and resulting transcripts were confidential and were not shared with anyone outside the evaluation team, other than the transcription company. In data presentation and reporting processes, quotes will be attributed by country and participant category only.

Respect

The Evaluation Team demonstrated respect for participants at all times by being prepared for data collection and using appropriate verbal and nonverbal communication throughout data collection activities.

Risks

The two main risks of this study (in addition to the regular risks that these populations face working and living in crisis-and-conflict affected contexts) are potential breaches of confidentiality or privacy due to a data breach and a potential for re-traumatization due to discussing services that beneficiaries received as a result of traumatic experiences. To reduce the risks to confidentiality and privacy, the Evaluation Team followed clear data management and security protocols and saved all data, including contact information for staff of PRM and service providers, on password, protected, encrypted servers. Contact information for staff was never linked to data except in one file with a key, which was be saved separately from the data. Contact information for beneficiaries was not collected at all. To reduce the risk of re-traumatization of service users, the data collection team designed participatory, appreciative data collection materials to allow participants the opportunity to reflect on what they have appreciated about the services. To mitigate the effect of re-traumatization, should it occur, the Evaluation Team only conducted data collection when a trained MHPSS counselor familiar with PoCs was available nearby to support as needed.

Benefits

Evaluation participants would not directly benefit from taking part in this evaluation. However, the results of the evaluation will hopefully strengthen PRM's MHPSS programming in the future, benefiting future refugees, internally displaced people, host populations, and migrants as well as the organizations that serve them.

Compensation

Evaluation participants did not receive compensation to take part in this study. Interviews with service users occurred in an easily accessible location for these populations, or a location where they received programming, and did not require additional expenditures for them, so a transportation stipend was unnecessary.

Data Collection Integrity

EnCompass' IRB conducted an ethics review of the evaluation protocol. The Evaluation Team also confirmed that a local review was not needed for social science research in Turkey and Bangladesh as IRBs in these countries are either set up for review of protocols from their host institutions only or primarily focused on medical, rather than social scientific, research.

All data collectors were required to follow the data collection guide and protocol for each tool to ensure consistency in application of data collection principles, integrity of data collection processes, and so that all participants have the same opportunity to contribute to the evaluation. If there were any concerns that data collection may put a participant at risk that would not be able to be mitigated, the evaluation team would return to PRM and implementing partner staff to ask for another methodology for collecting this information or another individual to interview. This dynamic, iterative process of assessing risk and responding to security concerns continued throughout data collection.

Secure Data Management

The data collection team was required to follow security protocols to ensure secure data collection and storage. This included protection of participant information, using secure communication channels, storing all raw and sensitive information on encrypted servers with restricted access, and destruction of all data after three years of secure storage.

Sensitization to MHPSS Considerations

Each data collection event included the presence of an MHPSS subject matter expert from the evaluation team. Prior to data collection, the Evaluation Team Lead trained other members of the evaluation team who were supporting data collection on how to evaluate MHPSS programs sensitively and appropriately. This was integrated into a group review of the principals of trauma-informed evaluation. The team reviewed and discussed training materials from the EnCompass Justice and Accountability project and reviewed procedures to ensure best practices. The team also role-played data collection together to familiarize themselves with these techniques prior to data collection with service users. The session included orientation to the World Health Organization's guide, "Psychological First Aid: Guide for Field Workers".

Prior to conducting data collection with service users, the Evaluation Team obtained relevant information about available psychosocial and counseling resources and mental health referrals as recommended by the implementing IO or NGO. Each participant received a referral sheet with relevant contact information. The Evaluation Team provided contact information for the data collectors, translators, and EnCompass IRB to the relevant NGO AAP representatives or managers if any issues were to arise.

Annex 5: Data Collection Instruments

Online Survey Tool

Informed Consent [Introductory Text]

EnCompass LLC has designed this Survey to collect data for the U.S. Department of State's (DOS), Bureau for Population Refugees and Migration (PRM). PRM has requested EnCompass to evaluate their Mental Health and Psychosocial Assistance (MHPSS) programming from 2018 – present. This Survey is intended for all PRM-supported partners, who are delivering MHPSS assistance.

The evaluation objectives are to: (i) assess PRM-supported programming to address MHPSS; and (ii) develop recommendations to update and strengthen PRM's MHPSS strategy and programming. As a partner in PRM's MHPSS programming, you are invited to participate in this survey because of your direct experience and knowledge. Through this survey, we hope that you will be willing to share that experience and knowledge, and any recommendations that could improve PRM's programming ahead. However, your participation is entirely voluntary, and you can choose to withdraw at any time. We estimate that the survey will take between 30 and 45 minutes.

We recognize that you may have been involved in multiple PRM-funded projects over the years. Please answer this survey specifically related to the MHPSS PRM funding you have received for your country program [for IOs, for all country programs]. If you no longer receive PRM funding, please answer about your most recent PRM-funded program. You may answer with other members of your team, but please submit only one response per country for your organization.

EnCompass will store the survey questionnaires and results electronically on password-protected computers and secure web-based data storage and analysis platforms. All Information obtained, analyzed, and reported will be kept anonymous. Your responses will not be presented individually or by organization, rather, all responses will be analyzed and reported

collectively. There are no right or wrong responses. Please read the questions carefully, and respond to each based on your own knowledge, expertise and experience.

If you have any questions or concerns prior to starting or in responding to the survey, please feel free to email the Evaluation Team Leader, Lynellyn Long, at llong@encompassworld.com, and evaluation specialist Ted Rizzo, at arizzo@encompassworld.com. A public version of our Evaluation findings will be available on the State Department website. Thank you, in advance, for the MHPSS work you do, your time, and participation.

Permission

1. Before responding to the questions below, do you consent to participate in this survey? (By checking 'yes', all team members working together to complete this survey consent to participate in this survey)

    - Yes
    - No

If "Yes" go to Q1

If "No" go to "End of Survey"

Demographic and MHPSS Profile

This section contains general questions about you, your organization, and timeline of your PRM-funded MHPSS programming. Your responses will be combined with those of other organizations for general background on MHPSS programming. We will not use these data to identify particular programs or individuals.

2. [Choose one] Please select the country in which your organization has implemented PRM-funded MHPSS programming over the last three years that you are most familiar with. If you have worked on programming in multiple countries, please coordinate with other members of your team to determine who is responding on behalf of which country. Please answer the remaining questions in this survey about the programming in that specific country. Note: For the purpose of this survey, a program is considered "PRM-Funded" if it received any funding from PRM, regardless of whether or not there was other donor support.

    - Afghanistan
    - Bangladesh
    - Brazil
    - Cameroon
    - Chad

- Colombia
- Democratic Republic of Congo
- Egypt
- Ethiopia
- Iraq
- Jordan
- Kenya
- Malaysia
- Mauritania
- Nigeria
- Pakistan
- Peru
- South Africa
- South Sudan
- Tanzania
- Thailand
- Turkey
- Uganda
- Venezuela
- Other (please specify)
- Prefer not to say

If participant selects "Prefer not to say" go to "End of Survey." All other responses, go to Q2.

3. [Choose one] In which year did your organization begin its MHPSS humanitarian programming in the country you indicated?

    - 2017
    - 2018
    - 2019

- 2020
- 2021
- Before 2017 (Please specify) _____
- Don't know
- Prefer not to say

4. [Choose Multiple] Has your organization received MHPSS-specific funding for your humanitarian work in your country from donors other than PRM? Choose all that apply.

   - International Organizations (e.g., UNICEF, WHO, UNHCR, IOM, ICRC)
   - The Government/National Ministry of Health)
   - Private Sector/Donors
   - Bilateral Government Organizations (e.g., USAID, FCDO, GIZ, CIDA, etc.)
   - Other (Please specify) _____
   - My organization only receives MHPSS funding from PRM in my country.
   - Don't know
   - Prefer not to Say

If the participant selected any of the donors (including "Other") go to Q4. All other responses go to Q5.

5. [Choose one] Who is currently your organization's largest donor for MHPSS-specific funding in your country?

   - PRM
   - International Organizations (e.g., UNICEF, WHO, UNHCR, IOM, ICRC)
   - The Government/National Ministry of Health)
   - Private Sector/Donors
   - Bilateral Government Organizations (e.g., USAID, FCDO, GIZ, CIDA, etc.)
   - Other (Please specify) _____
   - Don't know

- Prefer not to Say

6. [Choose multiple] With which populations has your organization worked on PRM-funded MHPSS funding in your country? Choose all that apply.

   - Refugees in camps
   - Refugees outside of camps
   - Internally displaced persons (IDPs)
   - Stateless people
   - Returnees
   - Asylum Seekers
   - Migrants
   - Local communities
   - Other (please specify)
   - Don't know
   - Prefer not to say

7. [Text box] What is your best estimate of the MHPSS-related caseload (i.e., the total number of direct beneficiaries of your MHPSS programming, including both intensive and non-intensive services across all levels of the IASC pyramid) in your current (or most recent) PRM-funded project? Note: If multiple donors funded a single project, including PRM, please share the total caseload. There is no need to disaggregate by donor. If you do not know the answer, write "Don't know." If you would prefer not to say the answer, write "Prefer not to say."

   - Last week? _____
   - Average monthly? _____
   - Highest year, to date? _____

8. [Text box] What is your best estimate of the number of people in your organization who currently work directly (employed or volunteer) on MHPSS programs in your country,

regardless of whether their role is funded by PRM? Please include staff members who provide administrative, monitoring and evaluation, or other background support to these programs. If you do not know the answer, write "Don't know." If you would prefer not to say the answer, write "Prefer not to say." _____

9. [Text box] Of these people, what is your best estimate of the number of people in your organization who currently work directly (employed or volunteer) on MHPSS programs in your country whose work is partially or fully funded by PRM? Please include staff members who provide administrative, monitoring and evaluation, or other background support to these programs. If you do not know the answer, write "Don't know." If you would prefer not to say the answer, write "Prefer not to say." _____

Questions to Guide State/PRM's Future Strategy and Programming

MHPSS Services – Some MHPSS programs are implemented as 'stand-alone' programs, meaning that the program only implements MHPSS related activities. Other MHPSS programs are 'integrated', meaning that delivery of the MHPSS activities are tied in with other sectoral activities.

10. [Grid, Chose one] Please indicate whether your organization has provided the MHPSS services listed below in your country using PRM-funding and, if so, whether the service has been stand-alone or integrated through a sector program? For the purpose of this question, "integrated" services are those where any of the following conditions apply:

    - Referrals to the MHPSS services are made through the particular sector
    - Sector staff are trained in MHPSS and provide those services
    - Services are directly located within the particular sector
    - Services are administered in that sector

For the purpose of this question, “stand-alone” services include programs that do not involve other sectors at all as well as those which are parallel and/or reinforce the work of sectors but do not involve direct engagement from the other sector and may serve several sectors and programs.

Table 9: Provision of MHPSS services

Type of Service/Intervention	My organization offers this service as a stand-alone service ONLY in my country	My organization has integrated this service with other sectors	My organization does not offer this service in my country	Don’t know	Prefer not to say
Advocacy and/or Awareness (e.g., IEC and Mental Health Commemoration Days)					
Training and/or Capacity Building for Community/Traditional / Religious Leaders					
Training and/or Capacity Building for your NGO’s Service Providers (e.g., teachers, nutritionists, WASH, etc.)					
Training and/or Capacity Building for other NGO/CBO Service Providers					
Training and/or Capacity Building for Primary Health Care, private and/or public health care workers					

Type of Service/Intervention	My organization offers this service as a stand-alone service ONLY in my country	My organization has integrated this service with other sectors	My organization does not offer this service in my country	Don't know	Prefer not to say
Training and supervision for Community PSS workers					
Social cohesion activities between IDP/refugees and host communities					
Individual MH (mental health) counseling					
Group MH (mental health) counseling					
Individual PSS (psycho-social support)					
Group PSS (psycho-social support)					
Peer-led MHPSS activities					
Staff counseling and support					
Safe Spaces					
Referrals to other service providers (NGOs, public/government or private)					
Vouchers/cash support for MHPSS services					
Research					

Type of Service/Intervention	My organization offers this service as a stand-alone service ONLY in my country	My organization has integrated this service with other sectors	My organization does not offer this service in my country	Don't know	Prefer not to say
Other (please specify)					

In question 11, only ask respondents about services for which they indicated "Integrated" above. If no sectors selected for integrated, go to Q12.

11. [Grid, choose multiple] Please indicate in which sectors your program integrates the services you identified above. Please choose all that apply.

Table 10: Sector integration of services

Type of Service/Intervention	Protection	Education	WASH	Livelihoods	Health	Nutrition	GBV	Other	Don't know	Prefer not to say
Advocacy and/or Awareness (e.g., IEC and Mental Health Commemoration Days)										
Training and/or Capacity Building for Community/Traditional / Religious Leaders										
Training and/or Capacity Building for your NGO's Service Providers (e.g., teachers, nutritionists, WASH, etc.)										
Training and/or Capacity Building for other NGO/CBO Service Providers										
Training and/or Capacity Building for Primary Health Care, private and/or public health care workers										

Type of Service/Intervention	Protection	Education	WASH	Livelihoods	Health	Nutrition	GBV	Other	Don't know	Prefer not to say
Training and supervision for Community PSS workers										
Social cohesion activities between IDP/refugees and host communities										
Individual MH (mental health) counseling										
Group MH (mental health) counseling										
Individual PSS (psycho-social support)										
Group PSS (psycho-social support)										
Peer-led MHPSS activities										
Staff counseling and support										
Safe Spaces										

Type of Service/Intervention	Protection	Education	WASH	Livelihoods	Health	Nutrition	GBV	Other	Don't know	Prefer not to say
Referrals to other service providers (NGOs, public/government or private)										
Vouchers/cash support for MHPSS services										
Research										
Other (response repeated from above)										

Please specify any other sectors in which your organization integrates these MHPSS services.

12. [Matrix, choose one] For each of the therapies listed below, please indicate whether this therapy has been used for individuals, groups, or both in PRM funded programming in your country. For many of these therapies, there are both manualized/standardized interventions used by many organizations and non-standardized, but similar, approaches used by individual organizations. For the purposes of this question, it does not matter whether your organization uses a standardized or custom approach to the therapy. Commonly known, manualized versions of some therapies have been included for reference only.

Table 11: Use of therapy/tools in PRM funded programming

Therapy/Tool	Individual ONLY	Group ONLY	BOTH individual and group	My organization has not offered this therapy in PRM funded programming in my country	Don't know	Prefer not to say
Psychological First Aid (PFA)						
Problem Management (PM+)						
Self Care/Self Help (SH+)						
Interpersonal Therapy (IPT)						
Peer-to-Peer (Peer+)						
Integrated Adapt Therapy (IAT)						
Community-based Sociotherapy (CBST)						

Therapy/Tool	Individual ONLY	Group ONLY	BOTH individual and group	My organization has not offered this therapy in PRM funded programming in my country	Don't know	Prefer not to say
Early Adolescent Skills for Emotions (EASE)						
Thinking Healthy						
Common Elements Treatment Approach (CETA)						
Eye Movement Desentization and Reprocessing (EMDR)						
Dialectical Behavioral Therapy (DBT)						
Cognitive Behavioral Therapy (CBT)						
mhGAP						
Other (please specify)						

In questions 13 and 14, only ask respondents about therapies for which they indicated "Individual," "Group" or "Both" responses above

13. [Matrix, choose multiple] Please indicate to which populations your organization has offered the therapies listed below in PRM-funded MHPSS programming in your country. Choose all that apply.

- Refugees in camps
- Refugees outside of camps
- Internally displaced persons (IDPs)
- Stateless people
- Returnees
- Asylum Seekers
- Migrants
- Local communities
- Other (please specify)
- Don’t know
- Prefer not to say

Table 12: Populations who have been offered listed therapies

Therapy/Tool	Populations listed above (each in its own column)	Other (specify below)	Don’t know	Prefer not to say
Psychological First Aid (PFA)				
Problem Management (PM+)				
Self Help (SH+)				
Interpersonal Therapy (IPT)				
Peer-to-Peer (Peer+)				
Integrated Adapt Therapy (IAT)				
Community-based Sociotherapy (CBST)				
Early Adolescent Skills for Emotions (EASE)				
Thinking Healthy				
Common Elements Treatment Approach (CETA)				

Therapy/Tool	Populations listed above (each in its own column)	Other (specify below)	Don't know	Prefer not to say
Eye Movement Desentization and Reprocessing (EMDR)				
Dialectical Behavioral Therapy (DBT)				
Cognitive Behavioral Therapy (CBT)				
mhGAP				
Other (response repeated from above)				

Please specify any other populations to which your organization offers with these therapies

14. [Matrix, choose multiple] Please indicate for which MHPSS health concerns your organization has offered the therapies listed below in PRM-funded MHPSS programming in your country. Choose all that apply.

    - Anxiety disorder
    - Depression
    - Suicide Ideation
    - Post-Traumatic Stress Disorder (PTSD)
    - Dementia
    - Substance Abuse
    - Other (please specify)
    - Don't know
    - Prefer not to say

Table 13: Concerns for which therapies have been offered

Therapy/Tool	Concerns listed above (each in its own column)	Other (specify below)	Don't know	Prefer not to say
Psychological First Aid (PFA)				
Problem Management (PM+)				
Self Help (SH+)				
Interpersonal Therapy (IPT)				
Peer-to-Peer (Peer+)				
Integrated Adapt Therapy (IAT)				
Community-based Sociotherapy (CBST)				
Early Adolescent Skills for Emotions (EASE)				
Thinking Healthy				
Common Elements Treatment Approach (CETA)				
Eye Movement Desentization and Reprocessing (EMDR)				
Dialectical Behavioral Therapy (DBT)				
Cognitive Behavioral Therapy (CBT)				
mhGAP				
Other (response repeated from above)				

Please specify any other MHPSS health concerns that your organization addresses with these therapies

15. [Grid, chose one] How frequently has your organization's PRM-funded MHPSS programming addressed the following MHPSS clinical disorders in your country across all populations? For the purpose of this question, addressing these disorders does not require a diagnosis or formal treatment, but rather any programming that responds to these concerns or provides referrals.

Table 14: Frequency of disorders addressed

MHPSS Clinical Disorder	Never	Sometimes	Often	Unsure/ Don't know	Prefer not to say
Anxiety Disorder					
Depression					
Grief					
Suicide Ideation					
Suicide Attempt					
Bipolar Disorder					
Schizophrenia					
Trauma					
PTSD					
Epilepsy					
Dementia					
Alcohol addiction					
Drug addiction					
Mental disorders in children					

MHPSS Clinical Disorder	Never	Sometimes	Often	Unsure/ Don't know	Prefer not to say
Other (please specify)					

16. [Grid, chose one] How frequently has your organization's PRM-funded MHPSS programming addressed the following MHPSS health concerns in your country across all populations?

Table 15: Frequency of health concerns addressed

MHPSS Health Concerns	Never	Sometimes	Often	Unsure/ Don't know	Prefer not to say
Intimate partner violence (IPV) survivor support need					
Sexual and gender-based violence (S/GBV) survivor support need					
LGBTI+ support needs					
Disability support needs					
Torture survivor support needs					
Other (please specify)					

17. [Grid, chose multiple] What methods has your organization used in PRM-funded MHPSS programming in your country to consult beneficiaries to integrate their perspectives into MHPSS programming? Check all that apply.

Table 16: Consultation methods used

Instrument	Pre-COVID	During COVID	My organization does not use this method	Don't know	Prefer not to say
MEAL Surveys and Interviews					
Suggestion Boxes					
Hotlines					
Facebook Groups					
Online Platforms					
Local Community Representatives' Meetings					
WhatsApp					
Other (please specify)					

18. [Grid, chose one] In the list below, please indicate the extent to which your MHPSS programming shifted resources and attention to address these issues during the pandemic?

Table 17: Extent of shift in programming resources and attention to address issues during the pandemic

Issue	N/A: not applicable	Not at all	Moderately	Significantly	Prefer not to say	Don't know
COVID Deaths						
Long-term COVID (health impacts)						
Inability to grieve or mourn deaths with public ceremonies						

Issue	N/A: not applicable	Not at all	Moderately	Significantly	Prefer not to say	Don't know
Lack of access to, or insufficient, COVID vaccines						
Less access with over-burdened medical services						
Loss of Livelihoods (employment or business)						
Loss of housing or shelter						
Increased in suicidal ideation/attempts/completed suicides						
Lack of Access to Educational Services						
Insufficient Food Supplies and deliveries						
Insufficient water and sanitation services (WASH)						
Increase in Substance Abuse						
Increase in Intimate Partner Violence						
Increase in S/GBV incidents						
Increase in trafficking and/or smuggling of persons						

Issue	N/A: not applicable	Not at all	Moderately	Significantly	Prefer not to say	Don't know
Lack of access to persons without internet (Digital Divide)						
Increase in refoulements						
Increased refugee/migrant waiting and processing times						
Increased tensions and/or conflict with national governments and local populations						
Increased tensions and/or conflict with national governments and local populations						
Other (please specify)						

19. [Choose one] Considering the list above, did your MHPSS caseload during the pandemic?

- Increase
- Remained the same
- Decrease
- Not applicable
- Don't know
- Prefer not to say

If the participant selected "Increase," go to Q20. If the participant selected "Decrease," go to Q21. All other responses go to Q22.

20. [Text box] By what percentage do you estimate the caseload increased? If you do not know the answer, write “Don’t know.” If you would prefer not to say the answer, write “Prefer not to say.” _____

Go to Q38.

21. [Text box] By what percentage do you estimate the caseload decreased? If you do not know the answer, write “Don’t know.” If you would prefer not to say the answer, write “Prefer not to say.” _____

22. [Choose multiple] Which of the following issues did MHPSS staff in your country and NGO experience as a result of COVID? Check all that apply.

- Loss of employment
- Salary cutbacks
- Increased work and caseloads
- Staff member had COVID
- Staff member had to care for family member/friend who contracted COVID
- Family member deaths
- Staff deaths
- Increased need for online supervision
- Secondary Trauma/Increased Mental Health Needs
- Burnout
- Other (please specify) _____
- Don’t know
- Prefer not to say

23. [Choose multiple] What interventions did your organization make to address MHPSS staff needs during COVID? Choose all that apply.

- Moved to 100% remote work
- Moved to partial remote work

- Provided extra training to staff to address pandemic issues
- Provided free vaccinations and/or protective equipment
- Provided counselling to staff
- Maintained salaries and hours to maintain staff employment
- Implemented COVID related sick leave benefits
- Implemented or increased sick leave benefits generally
- Other (please specify) _____
- Don't know
- Prefer not to say

24. [Comment box] What approaches has your organization taken to strengthen the MHPSS response system as a result of the COVID-19 pandemic?

25. [Multiple textboxes] Please list up to five indicators from the MEAL plan for your organization's PRM-funded MHPSS programming in your country that you feel best capture your MHPSS programming?

    a. _____
    b. _____
    c. _____
    d. _____
    e. _____

End of survey

Thank you very much for your time and responses to these questions.

Beneficiary – Focus Group Discussion Guide

This group discussion covers

- Situation assessment of key mental health challenges in their communities
- Identification of existing resources that they access
- Pathways and strategies used to make their requirements known
- SWOT analysis of those resources in light of challenges (individually, in pairs, or groups as preferred)
- Changes and recommendations for improving services and support
- Impact of COVID on their work and adaptations made
- Recommendations to address the new mental health realities in light of COVID-19 and other changes

Note: Do NOT ask about participants personal traumas/mental health situation. Focus only on their experience with the program and its impact (if any)

Instructions prior to the interview

Thank you all for agreeing to participate in this group interview. During this discussion, we would like to discuss your views on [IO/NGO]'s mental health and psychosocial support (MHPSS) programs.

1. What about the mental health and psychosocial support services you have received from [IO/NGO] do you feel responded well to your needs? In other words, what were the program's key strengths?

   Probe: any changes in the programs strengths due to the COVID-19 pandemic?

2. What about the services you have received from [IO/NGO] do you feel did not meet your needs?

   Probe: any challenges related to access to the program?

   Probe: how challenges changed due to the COVID-19 pandemic?

3. Looking at these points you have listed, what about the program could be changed in order to better meet your needs?

4. What mechanisms [IO/NGO] use to get feedback about the program from people like you?

   Probe: how those mechanisms changed due to the COVID-19 pandemic?

5. What changes to the program do you think happened because of feedback that [IO/NGO] received from people like you?

6. Other than this program, how do people in your community address mental health challenges and concerns?

   Probe: Who do you turn to for advice on mental health issues – parent, imam, traditional healer, public health care, etc.?

   Probe: for any changes due to the COVID-19 pandemic?

7. Thank you again for all your contributions in these activities. To finish our conversation, I want to ask if there is anything else you would like to tell us about your experience with the mental health and psychosocial support services program? Do you have any other recommendations?

Beneficiary – Individual Interview

Key areas of inquiry for this stakeholder group

- Perspective of usefulness of support received

- Influence that the support has held on their day to day lives
- Perspective on ability to provide feedback on program support
- Perspective on adjustments to programs given feedback
- Perspective on ongoing relevance of program given COVID

In addition, depending on the beneficiary, the team will inquire about:

- The MHPSS needs in the given community (age group, social network, etc.)
- Determine who helps. Who are considered the MHPSS experts
- Characterize the services and access
- Identify if there has been a digital divide and if so, how it has been addressed
- Obtain recommendations for better programming to address their MHPSS needs

Note: Do NOT ask about participants personal traumas/mental health situation. Focus only on their experience with the program and its impact (if any)

1. What did you most appreciate about the mental health and psychosocial support services you received from [IO/NGO]?

   Probe: Why did you appreciate this? How did it help you?

2. To what extent do you feel you were able to fully participate in the program?

   Probe : Appropriate timing of program, accessibly of location, barriers to MHPSS services

3. What about the [IO/NGO] program could change?

4. Other than this program, how do people in your community address mental health challenges and concerns?

Probe: Who do you turn to for advice on mental health issues – parent, imam, traditional healer, public health care, etc.

5. How can you provide feedback on the services you received?

   Probe: Who they provide feedback to and how they have been able to give feedback

6. How has your feedback been heard? What, if any, changes has it made to the programs in which you participate?

7. COVID: Tell me about your experiences with the program during the COVID-19 pandemic?

   Probe: their experience receiving online support. What feedback they have on online support

8. Is there anything else you would like to tell us about your experience with the program? Do you have any other recommendations?

NGO Programs (Onsite)– Individual Interview Guide

Key areas of inquiry for this stakeholder

- Describe the current context and how they deliver MHPSS services
- Profile the training, ID of needs, and M&E MHPSS data obtained
- Characterize referral pathways and strategies
- Describe beneficiary/client input and feedback and examples
- Determine the impact of COVID on their work and adaptations made
- Obtain their recommendations to address new MHPSS realities

1. Could you describe what needs MHPSS activities are addressing in your program, who you are serving, and what some of their needs are?

   Probe: Besides your programming, what other MHPSS support do your beneficiaries have?

   Probe: Medical service providers vs. non-medical service providers?

2. How do you identify and support individual and community MHPSS needs?

3. How do you make referrals, to where and to whom?

4. How do you track the performance of your MHPSS programming? How do you gather data and how is it used?

5. Do you keep any cost estimates on the cost of MHPSS work within your other programs?

6. What would be the role and/or benefits of standalone MHPSS programming? What are the benefits of cross-sectoral integration?

7. How do you obtain individual and different groups' perspectives and feedback in the communities you serve? Do you have an example of how an individual's perspectives and feedback changed your work?

8. How did COVID-19 affect the MHPSS needs of the people and communities you serve?

   Probe: For those programs that pivoted to online, were there issues of a digital divide and if so, amongst whom and how was the digital divide addressed? Changes in the strategy?

9. What were some of the emerging MHPSS needs and demands and how are you adapting your program to meet these new needs and demands?

10. What will be the future place and role of MHPSS programming in your work?

11. What recommendations do you have to improve MHPSS programs and services in the future?

UNICEF– Individual Interview Guide

Key areas of inquiry for this stakeholder:

- Identify NGOs/CBOs that the IOs support for MHPSS, which provide integrated, standalone services, and/or both?
- Determine how assurances of “Do No Harm” are obtained and verified
- Profile how the IOs and their implementing partners access and respond to diverse groups within given populations
- Analyze the effectiveness, cross-cultural relevance and/or adaptations, and scalability of different therapeutic interventions
- Specify kinds of training and human resources needed
- Describe localization strategies and their human resource and cost implications
- Identify DALY calculations in conflict settings
- Determine if MHPSS expenditures are disaggregated of MHPSS (does it happen) and M&E indicators
- Assess the relevance of the WHO MSP M&E five priority outcomes (evidence of data gathered and measured)
- Describe the role of the MSP in HCR programming
- Analyze the specific MHPSS components and programming across the four levels of the pyramid that have been scaled and/or have potential for scalability
- Characterize the impact of diminished humanitarian assistance on MHPSS programs and outcomes and changed modalities

- Ask for any panel data on MHPSS – pre and post COVID
- Determine whether and how the digital divide was/was not addressed and lessons going forward
- Identify referral pathways to PHCs, uptake and whether nationalization is working/can work in the current time
- Find out what the team needs to see and investigate in Turkey and Bangladesh and with WHO/UNICEF how best to follow up on the MSP trials

1. What are some of the impressive NGOs (international and local) that you support with your PRM funding [or in the case of WHO and ICRC, who do they think is innovating MHPSS on the ground]?

   Probe: Which provide standalone and which provide integrated services?

   Probe: What are some of the programming gaps that you were able to address with the PRM MHPSS support? What gaps remain?

2. Do you have any concerns about harmful practices in those you support and how do you assure "do not harm" – one of the six core principles of MHPSS support?

3. How do you and your implementing partners reach diverse groups within a given population and respond to their needs and concerns (AAP question)?

   Probe: Are there any examples of where their input changed an operation?

4. We have seen a move toward a localization strategy in supporting NGO MHPSS programming and especially during COVID. Is this happening with your own programming and if so, how is it working?

   Probe: Is it generally cost effective and if so, why?

Probe: What are some of the benefits as well as risks?

5. Our initial findings suggest that funds and human resources for MHPSS are limited and generally spread across several sectors. With cutbacks in humanitarian funding, what changes and adaptations have you made to ensure that cross-sectoral programs can continue to provide MHPSS services and referrals?

6. What kinds of MHPSS training do you provide to other sector providers and/or for MHPSS staff? What kinds of training should be followed up and/or scaled up further?

7. To what extent are MHPSS expenditures disaggregated in your programming? Assuming some tracking, are you able to derive any costs/beneficiary data for different interventions and if so, which have proven most effective?

8. Which M&E indicators do you use to track your MHPSS programming and are they disaggregated within sectoral programs? To what extent do they address the six core common principles (human rights and equality, participation, do no harm, building on available resource capacity, integrated support systems, and multi-layered support)?

   Probe: How is your monitoring done and feedback integrated?

9. Can you describe how the Minimum Service Package is being trialed and rolled out in the eight countries and what has been learned so far? How could the MSP affect the quality, effectiveness, and relevance of MHPSS programming? What are some of the expected immediate improvements?

10. For those programs that pivoted to online, were there issues of a digital divide and if so, amongst whom and how was the digital divide addressed? Changes in the strategy?

11. Given recent cutbacks in humanitarian funding, what were the most significant adaptations made to continue MHPSS services during COVID? What might you continue doing based on those experiences ahead?

12. Which MHPSS activities/interventions across the four levels of the pyramid have been the most successful and why? What is their potential for scalability? What are the challenges and lessons learned? What recommendations would you have for the donor community to optimize their MHPSS funding strategies?

13. Could you give us your advice on who to meet and your MHPSS work to see during our fieldwork in [country] in late February/March? What should we know about your programs there? Any reports we should read first?

WHO– Individual Interview Guide

Key areas of inquiry for this stakeholder:

- Determine how assurances of “Do No Harm” are obtained and verified
- Profile how the IOs and their implementing partners access and respond to diverse groups within given populations
- Analyze the effectiveness, cross-cultural relevance and/or adaptations, and scalability of different therapeutic interventions
- Specify kinds of training and human resources needed [ICRC example should be probed]
- Describe localization strategies and their human resource and cost implications
- Identify DALY calculations in conflict settings [mainly WHO]
- Assess the relevance of the WHO MSP M&E five priority outcomes (evidence of data gathered and measured)
- Describe the uptake on the Minimum MSP and piloting in the eight countries to date
- Analyze the specific MHPSS components and programming across the four levels of the pyramid that have been scaled and/or have potential for scalability
- Characterize the impact of diminished humanitarian assistance on MHPSS programs and outcomes and changed modalities
- Ask for any panel data on MHPSS – pre and post COVID
- Determine whether and how the digital divide was/was not addressed and lessons going forward

- Identify referral pathways to PHCs, uptake and whether nationalization is working/can work in the current time

- Find out what the team needs to see and investigate in Turkey and Bangladesh and with WHO/UNICEF how best to follow up on the MSP trials

1. How do you assure "do not harm" – one of the six core principles of MHPSS support – in your work?

2. How do you incorporate the perspectives of diverse groups within a given population and respond to their needs and concerns? Strategies and modes of communication and uptake? Any examples of where their input changed your assumptions or strategies?

3. We have seen a move toward a localization strategy and especially during COVID? What are your thoughts on this approach and how is it working? Is it generally cost effective and if so, why? What are some of the benefits as well as risks?

4. Our initial findings suggest that funds and human resources for MHPSS are limited and generally spread across several sectors. With cutbacks in humanitarian funding, what changes and adaptations have you made to your work and the MSP?

5. How has this affected participation on the IASC and how does that participation take place?

6. What kinds of MHPSS training should be provided to other sector providers and/or for MHPSS staff? What kinds of training should be followed up and/or scaled up further?

7. Are you able to derive any costs/beneficiary data for different interventions and if so, which have proven most effective?

8. Which M&E indicators address the six core common principles (human rights and equality, participation, do no harm, building on available resource capacity, integrated support systems, and multi-layered support)? What has been the uptake?

9. Can you describe how the Minimum Service Package is being trialed and rolled out in the eight countries and what has been learned so far? How could the MSP affect the quality, effectiveness, and relevance of MHPSS programming? What are some of the expected immediate improvements?

10. Have there been any changes in strategy in the MSP that reflect issues of a digital divide and if so, amongst whom and how was the digital divide addressed? Changes in the strategy?

11. Given recent cutbacks in humanitarian funding, what were the most significant adaptations made to continue MHPSS services during COVID and its impact on the MSP?

12. Which MHPSS activities/interventions across the four levels of the pyramid have the most potential for scalability? What are the challenges and lessons learned? What recommendations would you have for the donor community to optimize their MHPSS funding strategies?

Funders– Individual Interview Guide

Key areas of inquiry for this stakeholder:

- Perspective on alignment of program to those most in need
- Perspective on extent to which the program aligned with international good practices
- Perspective on integration of MHPSS program into other sector implementations
- Perspective on contribution
- Perspective on impact of COVID-19 and ability of programming to adjust
- Perspective on integration of MHPSS strategy and broader health strategy
- Perspective on extent to which the current strategy provides a foundation for the future
- Perspective on needed changes/updates to the strategy to better guide PRM policy/funding decisions

In addition, depending on who is being interviewed, data collectors might touch on:

- Characterizes coordination and collaboration across agencies
- Profile the NGOs and IOs they are supporting and how they were chosen
- Determine where MHPSS sits in their humanitarian programming and strategies
- Elicit some examples of best practices and lessons learned
- Alignment of MHPSS funding and human resources give implementation program
- Earn about the role of USG and different agencies on the IASC

1. Overall, what do you feel are the most critical needs that MHPSS programs should address?

2. Which of the groups that you work with do you feel are most need of MHPSS Programing? How do you meet their needs?

   Probe: What populations do you consider "most in need"? (e.g., girls and young women, LGBTQI, PwDs) What programming is available to them?

3. What is your assessment of how agencies are coordinating and collaborating on MHPSS programming?

4. Tell me about the integration of MHPSS programs that you are funding with other sectoral programs.

   Probe: Sectors that have proven especially relevant/Sectors that have not been as relevant/what has worked especially well/what better looks like.

5. We know that some programs are implemented as standalone programs. Thinking back on your experience with this program, when and how does this strategy work well? Is there a role for standalone programming moving forward?

6. What resources are needed for MHPSS programming moving forward? What are the most effective ways to leverage these resources?

7. How did COVID-19 change your MHPSS programming?

8. How should the current MHPSS strategy be adjusted to make a greater contribution given continued issues with COVID, or to ensure relevance in another pandemic?

9. What strategies inform your funding decisions?

   Probe: knowledge of MHPSS strategy and use in decisions.

10. What are the most important lessons you have learned that could be used to adjust MHPSS strategy going forward?

11. Is there anything else you would like to add about your experiences with the MHPSS programming or any further recommendations?

12. Do you have any thoughts for us or recommendations for our evaluation?

Annex 6: Desk Review Findings

This desk review was conducted as part of early evaluation inception activities and was included in the inception report.

Purpose

The purpose of the desk review is to review and characterize PRM's MHPSS portfolio. The expected outcomes are to:

1. Derive an understanding of the four evaluation questions from the perspective of different stakeholders
2. Provide observations and findings that may be validated in subsequent data collection
3. Inform data collection tools for an online survey and field investigations in two countries
4. Identify country field sites for data collection

Methodology

The desk review methodology consisted of initial consultations with 10 stakeholders, identification of key IO documents from 2018 to the present related to PRM-funded programming, and a review of the NGO/CBO proposals and reports.

Online Consultations

To understand how the PRM-funded programs were implemented and PRM's support for IO programming for MHPSS, the evaluation team consulted with key senior MHPSS advisors from four of five IOs (IOM, UNHCR, UNICEF, and WHO), and the four NGOs (CVT, IMC, HAIS, and [22]

[22] The ICRC Senior MHPSS Advisor had only recently assumed her post so that consultation will be held later.

JRS). In addition to the eight consultations, an evaluation team member also met with an IOM Manager in Bangladesh (as a potential field site) and with PRM's Refugee Coordinator in Geneva to organize the upcoming interviews with the IOs.

During the consultations, the IOs and NGOs advised on the research, the specific relevance and interpretation of each evaluation question in relation to their programming, and potential field site selection. They also provided critical documents for the desk review. Following each interview, the evaluation team summarized the main points of the consultation in an email to the participants for confirmation. PRM was copied on this communication and the evaluation team forwarded any documents received from the consultation to PRM as well. The evaluation team authored briefing documents following the consultations for future key informant and group interviews.

Desk review

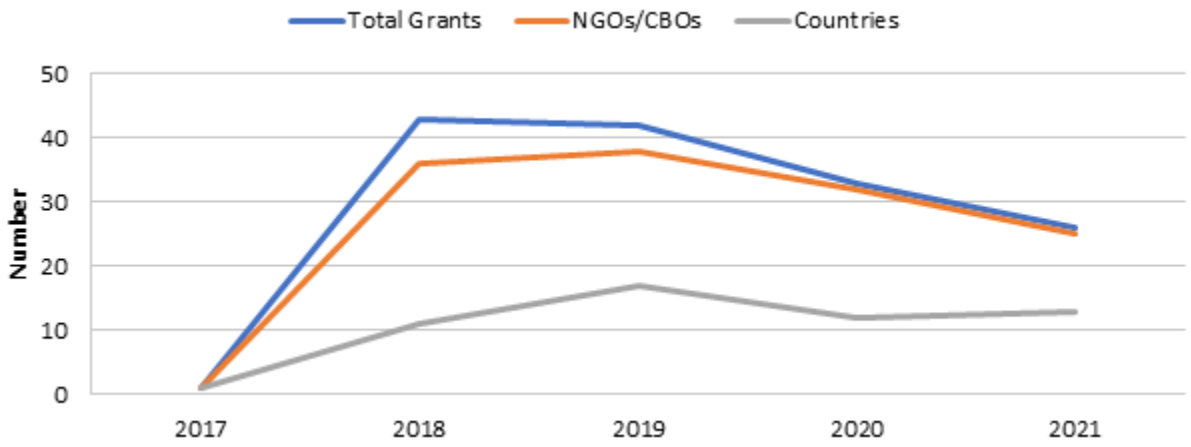
The evaluation team reviewed **145 NGO/CBO** files of proposals and reports covering PRM's global MHPSS programming from 2018 to the present. The 145 program files included proposals and reports covering 25 countries, 145 NGOs/CBOs, and two IOs (IOM and UNICEF).[23] The UNICEF files were two appeals. The team also received ICRC's 2021 survey report. The proposals from 2017-present, provided by PRM, allowed the Evaluation Team to characterize PRM's intended programming. The final reporting, provided by PRM, and the published UNHCR, IOM, ICRC, UNICEF, and WHO reports, covering their MHPSS programming during this period allowed the Evaluation Team to address preliminary reported outcomes (and any impact) relevant to the four evaluation questions.

During the consultations, the UNHCR, WHO, and IOM MHPSS advisors shared their most recent findings and reporting, which was then included in the following analysis. This desk

[23] Kurdistan Save the Children is treated as a separate NGO because the national organizations function independently.

review/inception report focuses on characterizing and summarizing PRM's MHPSS funding, as outlined in the proposals by the evaluation questions. It also provides observations and findings from the NGO and IO reporting to be validated further during data collection.

Exhibit 3: Number of new cooperative agreements awarded per year



As shown in Exhibit 3**,** the number of new cooperative agreements awarded varied by year, with 2018 being the peak year. These numbers only capture the first year that the cooperative agreement was awarded. The number of agreements being implemented in any given year was higher, particularly as PRM provided an increasing number of multi-year awards. The number of cooperative agreements in 2017 was also higher because the evaluation team only reviewed two 2017 proposals that extended through 2018. Because of the multi-year agreements, the number of new agreements each year does not correspond to the expenditure level for that year, but rather, serves as an indicator of new activity.

From the data provided, the three countries with the most MHPSS NGO/CBO programs in this portfolio review were: Jordan (22), Turkey (21), and Thailand (19). All three countries have diverse groups of PoCs from protracted and chronic emergencies. From the same data, the five NGOs that received the most cooperative agreements for MHPSS interventions were: IMC, with 18 awards across seven countries; CVT, with 12 awards across four countries; JRS, with 11 awards across five countries; HIAS, with eight awards across six countries; and International

Rescue Committee (IRC) with eight awards across four countries. These NGOs, which work in several countries, also received multi-year funding.

The evaluation team also reviewed program files and policies, operational guidelines, and research reports authored by ICRC, IOM, UNHCR, UNICEF, and WHO from 2018 to the present. In reviewing all documents, the evaluation team focused on humanitarian and emergency operations that may have directly or indirectly benefited from PRM funding from 2018 onwards and question guides for group and individual semi-structured interviews for subsequent evaluation field research (to be provided prior to data collection launch).

Desk Review Findings across Evaluation Questions

Guided by "IASC's MHPSS Pyramid" (2007), PRM's IO and NGO MHPSS portfolio may be characterized as supporting multi-faceted and horizontally and vertically layered assistance across all four pyramid levels, with most assistance focused on the first three levels.[4] Through its IO and NGO funding, PRM promotes ***integrating MHPSS interventions*** across all sectors (particularly health, protection, nutrition, education, and livelihoods) to provide basic services and security. These MHPSS interventions are then targeted to developing community and family support and potentially reach large numbers of PoCs.

PRM's portfolio also supports vertical programming for referrals to specialized psychological and mental health services, representing the top two pyramid levels. Such targeted funding, aimed at the 22 percent of PoCs with acute needs, supports individualized counseling therapies, specialized trauma" therapies, and care for post-traumatic stress disorder (PTSD) (e.g., Eye Movement Desensitization and Processing – EMDR); PHC staff training; and MOH training and capacity-building. Several ***standalone and specialized, expert interventions***, including research, specialized mobile teams, clinical training, therapeutic support, and supervision, also address MHPSS programming at the start of emergencies to respond proactively and quickly to severe grief, trauma, and distress.

From 2018 onwards, PRM's MHPSS programming strategy has provided multi-faceted support to respond to new and prolonged emergencies. This support has ranged from addressing basic needs, so service users feel safe and secure to organizing specialized care for individual service users with mental health conditions through national health systems. PRM-funded programs build local capacity at several levels, from countering resistance and stigma around MHPSS to training local health care providers and providing specialized psychological services. The magnitude of this issue, particularly during the COVID-19 pandemic, suggests that identifying measures and ways to scale and sustain MHPSS services will be an ongoing priority. In recognition of the time it may take to develop effective and sustained MHPSS support, PRM also instituted a multi-year framework for providing funding and programming. Not surprisingly, this decision was widely appreciated.

PRM's continued MHPSS support through sector and standalone programming prioritizes cultural and local relevance, cost effectiveness, and integration into national health systems. However, capacity, resources, and support from PHC clinics and health ministries also need to be in place to ensure effective, sustained provision. Such integration into national health care systems is one of five key objectives of UNHCR's current 5-year plan.

PRM's health strategy recognizes that "mental health is an intrinsic part of health care" (UNHCR 2021: 45). Because of the complex health needs of those who are uprooted and living in war and conflict, PRM's implicit underlying theory of change is to:

> *Develop the knowledge and capacity across sectors and health systems so that all humanitarian and emergency operations will be able to respond in a timely and sustainable way to the growing MHPSS needs of PoCs.*

Through training and support for local populations to provide PSS services and for primary and national health care staff to provide specialized mental health services, PRM-supported IOs and NGOs are working to scale and sustain these services. Thus, MHPSS programming support for the three major IOs and for many NGO/CBO country programs underpins the Bureau's mandate

"to provide life-saving assistance and protection to the world's most vulnerable people" (DOS Congressional Budget Justification FY 2022, 95).

Evaluation Question 1: Targeting and Best Practice

Evaluation Question: To what extent have PRM-supported programs, both IO and NGO, contributed to meeting the MHPSS needs of refugees and IDPs?

PRM-funded interventions focus mostly on the first three layers of the IASC pyramid (specialist services, non-specialized supports, and community and family supports). Interventions predominantly address MHPSS community outreach and support, training and capacity-building, individual and group counseling, and referral pathways and system development.

Most PRM-funded IO and NGO/CBO programs provide mental health and/or PSS interventions to address one or more of the first three layers of the IASC (2007) pyramid. The interventions most cited in the NGO/CBO program proposals and documents are: 87 NGOs/CBOs providing MHPSS community awareness campaigns, outreach, and support programs; 92 conducting training and capacity-building; 91 providing individual counseling services and 89 providing group counseling services; and 74 developing referral pathways and/or other MHPSS system development.[5]

The IOs work across sectors and programs and support NGOs and CBOs to deliver MHPSS services. Their MHPSS modalities, focus, and priorities, however, differ:

- **ICRC** supports and trains first responders, including community leaders, health staff and MHPSS professionals to provide support to individuals and groups in situations of armed conflict.
- **IOM**, as part of migrants' protection, provides training, expert PSS mobile teams, and hubs in camps and host communities.

- **UNHCR** prioritizes community-based protection, training, referrals, and integration into national health and primary health care systems for refugees.

- **UNICEF** raises awareness of children's and families' particular distress; supports families and communities in developing systems to respond; and provides guidelines and tools aimed at children, families, and other caregivers.

- **WHO** provides research, guidelines, and expert advice; identifies gaps in services; and documents effective programming strategies and interventions.

Most NGO/CBO programs, funded directly by PRM or indirectly through ICRC, IOM, and UNHCR, have advocacy and awareness campaigns to increase PoCs' and locally affected populations' knowledge of mental health and to counter stigma. These campaigns may involve providing information and training to PoCs, including community and religious leaders, traditional healers, and representatives of identity and interest groups (e.g., women, sexual and gender-based violence [S/GBV] survivors, PwDs, youth, and/or LGBTIQ+ persons). Awareness campaigns are also carried out through International Mental Health Day and other commemoration events. NGOs and IOs funded since 2020 report that the COVID-19 pandemic may have increased people's willingness to learn about and seek MHPSS services.

To respond effectively, staff and community volunteer MHPSS training is critical to having the capacity to meet the increased demand. ICRC trains and supports first responders and, provides frontline, immediate MHPSS support and expertise in conflicts. In its most recent survey of 163 national International Federation of the Red Cross (IFRC) and ICRC societies, International Red Cross Red Crescent Movement partners, 94 percent report providing MHPSS support, 81 percent report having one or more MHPSS focal points, and 70 percent report making referrals (ICRC and IFRC, "Mental Health Matters" 2021, 2). The International Red Cross and Red Crescent Movement's human resources capacity has grown significantly in the past two years (since the last survey in 2019). In 2021, IFRC/ICRC's staff includes social workers, psychologists, psychiatrists, and community health workers (ICRC and IFRC 2021). These professionals are also supported by MHPSS volunteers, including social workers, psychologists, psychiatrists, and

community health workers (ICRC and IFRC 2021). More than 40,000 staff and volunteers were trained in PSS this past year. As a best practice across cultures, the Movement trained 80,000 people in Psychological First Aid (PFA), a practice developed by the

National Center for Post Traumatic Stress Disorder (NC-PTSD), a section of the United States Department of Veterans Affairs and adopted by many national health care systems during the COVID-19 pandemic. PFA focuses on how to support those suffering crises and emergencies by "Look, Listen, and Link" and is especially relevant to first responders who need to reduce initial distress, to encourage short and long-term functioning and reduce the likelihood of trauma symptoms.[6]

When establishing programs, several providers mentioned using IASC/WHO's "4W" approach ("Who does what, when, and where") to map and identify gaps in MHPSS services. If done in collaboration with cross-sectoral teams, it will be useful to learn which services are prioritized by sector (e.g., referral information in a WASH program or empowerment training in a livelihoods program). For triaging and referrals, WHO has also developed an intervention guide for medical and PHC workers, planners, and managers to address mental, neurological, and substance abuse. The guide outlines mental, neurological, and substance abuse conditions and provides algorithms for clinical decision-making. Given the role of PHC clinics in addressing these issues, part of identifying best practices will be to characterize PHC providers' case management strategies starting with prevalence of different MHPSS disorders in a given community, how they are identified, who is referred and at what point, and what care, support, and follow-up is then provided.

All IOs, and many PRM-supported NGOs and CBOs, have developed and offer a range of individual and group counseling support activities. UNHCR has identified several scalable, psychological therapies for individual and group counseling (UNHCR 2021, 46–7), which include:

1. ***Problem Management +***, based on cognitive behavioral therapy, for individuals and groups to address depression, loss, and role transitions

2. ***Interpersonal therapy*** for individuals and groups to address loss, interpersonal conflict, and social isolation; used with South Sudanese refugees in Uganda and refugees and migrants in Europe

3. ***Self-Help +*** for group therapy to address mild to moderate depression, anxiety, and distress

4. ***Integrated Adapt Therapy*** based on elements of cognitive behavior therapy and providing six sessions for groups to address psychological symptoms (used with refugees in Burma, Malaysia, Bangladesh, and Australia)

5. ***Community-Based Socio-Therapy*** for individuals and groups of 15 to address marginalization, mistrust, and social connectedness; used in several countries, including Rwanda, Burundi, the Democratic Republic of the Congo, Liberia, Uganda, and Ethiopia

6. ***"Thinking Healthy"*** to provide group support for perinatal depression; used with women in Pakistan, India, and Yemen

7. ***Common Elements Treatment Approach*** for individuals and groups of 8 to 12; used with IDPs in Iraq and Ukraine, refugees in Thailand and Ethiopia, and nationals in Zambia and Myanmar

8. ***"Friendship Bench,"*** an individual problem-solving therapy followed by peer-led group support; currently being trialed in Zimbabwe.

Many of the PRM-funded NGO country programs proposed individual and group counseling interventions but do not necessarily specify the approach or effectiveness of therapeutic approaches used. For cross-cultural relevance and scalability, it will be useful to learn if/how other PRM-supported, NGO/CBO providers are using and/or adapting these psychological interventions and what other therapies have been found to be effective and should be targeted for specific populations.

UNICEF and Save the Children remain at the forefront of addressing child protection and MHPSS needs. In its 2021 "State of the World's Children: On My Mind," UNICEF, because of the

COVID-19 pandemic, focused for the first time on child and adolescent mental health. The report examines MHPSS risk factors in families, schools, and communities arising from the pandemic. UNICEF is also developing MHPSS guidelines and best practices for children on the move to address these risk factors in migration and climate change. UNICEF's MHPSS advisor noted that migrant children are suffering more than ever from bullying and stigma in host communities and school systems. She also observed that the COVID-19 pandemic has increased parents' and caregivers' stress with resulting increases in child abuse and intimate partner violence.

IASC and the IOs at both headquarters and country levels have developed COVID-19-specific guidelines and interventions to respond during different pandemic levels (one to four). For example, IOM/Bangladesh developed "Guidance for MHPSS Services in COVID-19 Isolation and Treatment Centres, Cox's Bazar, June 20." The IOM/Bangladesh MHPSS team recognized the impact that testing positive and being isolated was having on the mental and psychological health of both the person isolated and their family. The IOM team adapted the IASC COVID-19 guidelines to the Cox's Bazar context to provide PFA and other mental health support for families and mobile phone counseling for those in isolation. For the worst-case scenarios, where families could not carry out funerals, IOM/Bangladesh worked with local religious leaders to develop alternative rituals for mourners.

To address the growing demand for specialized care and counseling, IOM (with funds from PRM and other donors) developed a 1-year MHPSS masters' certificate program at the University of Ankrah with supervised fieldwork.[7] Graduates from this program are working with different NGOs and refugee/IDP sites in Turkey, Mozambique, and the United Kingdom. IOM has also offered weekend MHPSS programs in Syria, Lebanon, Nigeria, and Serbia and short courses in Italy, Palestine, and Kosovo.

The PRM NGO/CBO providers universally provide monitoring, evaluation, assessment, and learning (MEAL) systems in their proposals. The characteristic outcome measure is assessing service user satisfaction with services provided, often quarterly and/or before, during, and after the interventions. Most NGOs/CBOs have outcome measures, and some have impact measures.

Several IOs and NGOs reported significant interventions to develop referral pathways and systems to sustain MHPSS services through their cross-sectoral interventions. These include ensuring that their sector providers know how to make referrals for more specialized care; identifying MHPSS protection needs early on; creating playgrounds and safe spaces for counseling and support activities; and delivering basic and vocational education (e.g., empowerment training) in ways that reinforce PSS. These key components are not necessarily addressed by one NGO, but rather, often reflect coordination across several IOs and NGOs to develop a multi-sectoral and layered approach.

PRM funding for NGO/CBOs suggests a trend toward supporting more local CBOs, who partner with, or may have been trained by, international NGOs. The majority of the funding is also integrated into sector programming. Where data are available, the annualized direct cost per beneficiary of integrated programming ranges from $6.16 (IMC in Ethiopia) to $2,536.26 (IOM in Thailand) This range reflects different countries (where costs will differ). The IMC $6.16 direct cost per beneficiary for specific MHPSS integrated interventions provides an accurate cost calculation of the MHPSS integrated programming cost for one country, Ethiopia. In contrast, IOM's high cost per beneficiary in Thailand reflects a mix of costs across several sectors and program activities. A more useful indication of the range of MHPSS annualized direct cost per beneficiary may be derived from the 12 MHPSS standalone awards, where costs range from $21 to $483.33, with an average of $264.22 per beneficiary. The cost variation also reflects country differences.

In scaling and sustaining MHPSS operations, PRM-funded IOs and NGOs, where there is capacity, work directly with PHC clinics and provide services through national health ministries. Community and sector staff are trained to refer service users for specialized MHPSS support and PHC clinic staff are trained to refer them to regional or national MOH clinics and hospitals. Specialized services, however, may be far from refugee and IDP camps. As reported during the consultations (November and December 2021), many service users depend on expensive medication and psychiatric care in public and private hospitals. NGOs, such as CVT and IMC, which work with trauma and torture survivors, are therefore helping train local and national

providers to offer specialized MHPSS. By engaging with PHC clinics and MOH systems in middle income countries, MHPSS providers can help improve the quality of care and develop referral pathways to increasingly specialized care. That support and training may also benefit the host country health systems. However, many low-income countries lack mental health care for their own populations and have limited capability to address specialized needs. As one NGO reports, Chad, for example, has only one trained psychiatrist for the entire country. Although building referral pathways and capacity up the pyramid is best practice for scaling and sustaining MHPSS capacity, developing a comprehensive system will require a "relief-to-development" strategy with extensive training, supervision, and capacity-building.

Evaluation Question 1.1 Effectiveness of Integration Programming

The 2007 IASC Guidelines called for a multi-sectoral approach with services and supports that were multi-layered and not only carried out by specialists (UNHCR 2021, 44). ICRC reports that in its latest survey of 163 national societies, the societies' preference is for integrating ("mainstreaming") services followed by a mixture of standalone and integration (ICRC 2021, 16).

In the PRM-funded IO and NGO programs, MHPSS services are integrated into the protection, nutrition, child protection, education, livelihoods, shelter, and WASH sectors and reproductive health, HIV/AIDS, and S/GBV programs. MHPSS services are carried out by a range of actors (professional medical/health staff, other sector staff, community members, traditional and religious leaders, and volunteers). For referrals to more specialized services, health, protection, nutrition, and education potentially play key roles. Many NGOs/CBOs have MHPSS interventions that are directly tied to health programs and referrals to other NGOs/CBOs offering mental health services and/or to national health care systems.

Integration across sectors and programs is widely reported by IOs and NGOS as critical for identifying and referring those with MHPSS needs to the appropriate services and level of care, avoiding stigma, and addressing the multi-faceted MHPSS needs of PoCs. Within each

sector, providing PSS support is seen as the responsibility of all. Protection officers, teachers, and nutrition workers play key roles in identifying the MHPSS needs in their communities.

For children with psychological needs, for example, is not sufficient to refer them to a trained clinical psychologist or psychiatrist; frontline educators need to be able to create supportive environments. They can intervene to address the stigmatization of refugee and/or affected local populations of children and classroom bullying. Teachers, if trained, are also most likely to witness and identify girls who may be victims of S/GBV and child abuse. Likewise, protection officers and nutritionists may be the first to recognize PTSD or intimate partner violence cases.

A challenge for effective sector integration in emergency programming is convincing frontline workers to obtain the expertise and training to take on MHPSS.

During the consultations IOs and NGOs raised concerns about whether frontline workers have the capacity and time to identify MHPSS needs and make appropriate referrals and the expertise to provide support without potentially causing harm. In this regard, PFA training may be relevant across all sectors and for all humanitarian workers. A serious concern about integrating MHPSS funding and interventions into other sectors (expressed by NGOs and IOs alike) is that the funds, commitment, and tracking of critical MHPSS indicators are not sufficiently understood as part of "basic needs" in emergency programming. Thus, the increase in the International Red Cross and Red Crescent Movement's human resources capacity is encouraging and, as a model, could be explored further.

Evaluation Question 1.2 Effectiveness of "Standalone" Programming

Standalone MHPSS programming with targeted funding has allowed emergency and humanitarian programs to develop a range of MHPSS services, from community-based to highly specialized mental health support. The targeted funding has helped in developing new counseling techniques and specialized trauma support, community engagement strategies, and referral pathways. Standalone MHPSS programming may have also helped in identifying

cultural adaptations to engage religious and traditional leaders and healers in the communities in providing effective support.

PRM's support for some leading NGOs offering standalone MHPSS services increased the knowledge base, expertise, and capacity for all the humanitarian community.

Standalone programming is also particularly useful for interventions research, knowing when and how best to adapt interventions to fit the local context, and providing models of supervision. More than one IO MHPSS advisor observed that PRM's support for some leading NGOs offering standalone MHPSS services increased the knowledge base, expertise, and capacity for the whole humanitarian community. From some of the lessons learned from the Safe from the Start programming for S/GBV survivors, MHPSS advisors also observed that it is important to have focused MHPSS expertise available at the beginning of an emergency to ensure that the technical capacity and resources exist to integrate these services across sectors. This same focused, standalone expertise may also be most relevant when transitioning to national MOH systems to ensure cost effective and sustainable, specialized care that is informed by the latest research and evidence. The standalone programming may also be most relevant to informing the Bureau's health strategy and programming.

Evaluation Question 1.3 Challenges, Gaps, and Adaptations

PSS programs are a necessary but not sufficient component for those with a serious mental health condition.

Meeting and increasing demand with limited/diminishing resources

A major challenge for NGOs and IOs providing MHPSS services to PoCs is scaling and sustaining work where demand is increasing but donor resources are declining. Although there has been increasing international recognition of the importance of MHPSS during the COVID-19 pandemic, mental health currently only receives two percent of government health budgets (WHO Meeting June 12, 2021 citing the most recent Mental Health Atlas). Given that

an estimated 90 percent of the global population has PSS needs, and 22 percent have mental health conditions (WHO consultation June 12, 2021), the PRM-funded IOs and NGOs can only address a small percentage of demand. Uprooted populations also face many different mental health and PSS needs at every point of their uprooting, journeys, and after obtaining temporary settlement or durable solution. Those displaced and living in camps and settlements for years and generations are also more likely to be at risk for acute and chronic disorders. For example, young adults caught in prolonged refugee situations reportedly are at increased risk of suicide ideation, serious depression, substance abuse, and suicide (HIAS, IMC, and IOM consultations, 2021). Overall, there is no short term or immediate fix; addressing the MHPSS of PoCs will require sustained support and changes in national health care priorities and budgets.

Mental health needs of young adults

Two mental health conditions prevalent in young adult PoCs are addiction and substance abuse (including prescription drugs) and suicide ideation and suicide. Both are cited in the Sustainable Development Goals and by IO/NGO practitioners. These issues need to be addressed early on and will require sustained support.

Addressing the gap between mental health and PSS

In delivering services, several MHPSS experts observed that the issue of “do no harm” remains a serious concern. PSS programs are a necessary but not sufficient component for those with a serious mental health condition. Practitioners are concerned that some of the community PSS services are causing harm if the providers are not properly trained on the limits and boundaries of their service provision. Collaborations with local traditional and religious leaders are critical, but those with a political or “gender reform” agenda or who take advantage of the PoC’s vulnerability to convert can cause harm.

In 2016, mental disorders and addictions caused 7% of the global burden of disease as measured in DALYs (daily adjusted life years) with depression accounting for the highest burden (Rehm and Shield 2019). As the WHO mental health researchers observe in Lancet (2019), the

"burden of mental disorders is high in conflict-affected populations." Based on a review and meta-analysis of existing studies and data sets, the authors report that "more than one in five people (22·1%) in post-conflict settings has depression, anxiety disorder, post-traumatic stress disorder, bipolar disorder, or schizophrenia and that almost one in ten people (9·1%) in post-conflict settings has a moderate [of] severe mental disorder at any point in time. At the same time, as noted, systemic support for mental health is limited or non-existent in many low-income countries, particularly for those who need specialized services.

Practitioners also observed that specialized services, in many countries, are largely provided through religious leaders and psychiatric hospitals. Such hospitals are often mostly private, and even public services often require some payment. Therefore, local populations without the financial means may not have access to specialized care even if available. NGO and IO programs are addressing this gap by providing vouchers for some of the most vulnerable groups (e.g., S/GBV survivors, PwDs, older people) to access specialized care. NGOs with MHPSS expertise are also providing trauma and PTSD care and supervision, and training local health workers to provide specialized psychological care and services.

Building a sustainable system

MHPSS systems cannot be managed and sustained by outsiders. The engagement of outsiders to collaborate and innovate remains relevant, but to be cost effective, day-to-day case management, counseling, and support will need to be local. MHPSS practitioners speak of building local and national capacity to sustain an MHPSS system over time in ways that suggest a "relief to development" strategy and time frame. Having some sense of how that transition is best organized and what an ideal outcome would be useful in future planning and prioritizing.

Humanitarian organizations have unique opportunities during crises to change the conversation on what really matters. In moments of crisis, people are often forced to recognize that they have deep needs and values that require different ways of acting and seeking support. For many people who are used to being independent and self-sufficient, such events may require a lot more help and support than they are used to receiving. MHPSS services need to be ready at

the outset to meet increased awareness and demand.[8] With an increasing number of prolonged emergencies, these early interventions need to evolve and adapt to chronic needs and demands.

This review found several adaptations that PRM-funded NGOs are implementing to build sustainable systems of care. Service providers report strengthening the capacity of sector managers and other refugee and humanitarian NGOs and CBOs, training PHC providers to assess MHPSS needs, and developing referral pathways. They are also introducing new counseling and intervention techniques, particularly for those with acute mental health needs (e.g., those suffering from trauma and PTSD). Finally, they are training local and national providers to take over specialized psychological and mental health support. There is a discernable pathway in the reports from introducing and providing MHPSS to training and supervising local and national providers to building long-term collegial relationships to sharing knowledge across countries and systems. There is also a trend of NGOs either engaging CBO partners from the beginning and/or turning their work, over time, to local NGOs and CBOs.

Overcoming mental health stigma

Stigma and the lack of knowledge about mental health and psychosocial well-being remain a worldwide problem, reflected in inadequate resourcing and service provision and reluctance to accept services. Advocacy and awareness campaigns, even when taken on by community members, may only go so far if there are not effective services and support in place. Engaging different religious and traditional leaders and healers, who are often the first consulted, to provide PSS in effective ways remains critical.

Developing a common terminology around issues of well-being, resilience, and functioning

Several IO MHPSS advisors observed the need to develop a common MHPSS terminology. Even with specific counseling regimes, there can be significant differences in interpretation and procedure, which may be widened across different borders, cultures, health practices, and sectors. As seen in the proposals, the field has hundreds of acronyms that often lack common

definition. This lack of common understanding also poses problems for measuring and assessing program outcomes and impact. The WHO and UNICEF are currently developing and trialing an MHPSS Minimum Service Package in five countries, which is expected to help in developing a consistent terminology, sector protocols, and standards.

Evaluation Question 1.4 Evidence on Program Effectiveness

During COVID-19, PRM's programming effectively supported UNHCR's 2013 Operational Guidelines that "humanitarian actors should not necessarily do different things; rather do things differently" (cited in UNHCR 2021).

The preliminary evidence is that PRM funding supported key humanitarian IOs and NGOs with MHPSS expertise to trial and develop MHPSS interventions and services at the outset and across sectors. The areas mentioned during the consultations, where PRM's funding may be most effective, are in:

- Providing some standalone MHPSS support at the onset of emergencies to integrate these services effectively across sectors and in communities
- Supporting specialized trauma and PTSD care and training
- Supporting the IO/NGO training and capacity-building for PHC providers to develop effective referral pathways and specialized psychological care

These preliminary findings should be followed up on, assessed, and validated first during the next evaluation stages.

NGO MHPSS practitioners also appreciated the funding to providers and PoCs throughout the pandemic and that PRM was "continuing to be present" (to be discussed further in the section on the impact of the COVID-19 pandemic). Going from one year to multi-year funding was seen as important to program effectiveness because building ownership and the capacities of a multi-sectoral and multi-layered system do not happen overnight. During the COVID-19

pandemic, PRM's programming effectively supported UNHCR's 2013 Operational Guidelines that "humanitarian actors should not necessarily do different things; rather do things differently" (UNHCR 2021). These preliminary findings suggest that the COVID-19 pandemic has changed MHPSS operations.

Evaluation Question 2: Integrating Service User Needs and Perceptions

PRM's proposal process mandates an "Accountability to Affected Populations" strategy. Most NGOs and CBOs have detailed plans and practices in place. However, some appear to repeat "Notice of Funding Opportunity" requirements but do not outline the specific activities that will be undertaken to ensure accountability. The Accountability to Affected Populations integration is usually evidenced in the program designs and MEAL reporting.

Evaluation Question 2.1 Service User Consultation and Feedback

New technologies to consult with service users and obtain their feedback were introduced to address the "digital divide" and lack of Internet access in several locations.

The desk review of NGO proposals and reports suggests that NGOs are using one or more of three Assistance to Affected Populations strategies to obtain service user consultation and feedback:

1. Detailed MEAL plans and designated officers, indicators with quarterly surveys, and pre- and post-tests for interventions (particularly, for training activities)

2. Assessing PoCs' communication preferences and offering a range of technologies, including suggestion boxes, WhatsApp, Facebook groups, and online platforms

3. Face-to-face interactions and designated troubleshooters in communities

It would be useful for the evaluation team to learn which strategies motivate service users to respond (i.e., generate a high response rate) in different contexts.

Since client/beneficiary satisfaction is universally reported at 95 percent or above, it is unclear how this indicator is discerning for measuring service user feedback. Many service users, when being provided any service, may be reluctant to offer a candid assessment. An encouraging trend in the recent proposals is the inclusion of outcome and impact indicators of service user functionality and well-being through a case management approach. Many NGOs/CBOs provided detailed monitoring and reporting on pre- and post-tests. However, some of the reporting may also benefit from case studies and narratives to address the how and why of PoC engagement and program adaptations.

Service providers expanded the range of communication technologies during the COVID-19 pandemic as face-to-face interactions and discussions were limited or shut down. IOM/Bangladesh, faced with service users with positive COVID-19 cases in isolation, provided cell phones to patients and families, and facilitated video calls when possible. New technologies to consult with service users and obtain their feedback were introduced to address the "digital divide" and lack of internet access in several locations.

NGOs and CBOs depend on a variety of community informants to obtain feedback, including translators, staff, community leaders, and clients. They also report holding small focus group discussions and deriving information from counseling and support groups. These discussions and focus groups may be held in recreational and "friendly, safe" spaces with children, S/GBV survivors, women, and youth.

Evaluation Question 2.2 Program Adaptations Reflecting Service User Feedback

This issue needs to be explored further in the planned survey and fieldwork interviews. It may be that the adaptations are best evidenced in sequential proposals and activities, which are followed and verified by PRM's Refugee Coordinators and Program Officers. There is not yet

enough evidence on the relative effectiveness of different technologies (e.g., those adopted during the COVID-19 pandemic) in obtaining service user feedback and how that feedback, in turn, led to specific program adaptations. For example, did the suggestion boxes or WhatsApp groups used by women to report stress and anxiety during the pandemic lead to group counseling online sessions? Several adaptations made during the COVID-19 pandemic, discussed in the next section, implicitly reflect service user feedback and the need to engage in new ways, but do they work effectively, and will they be sustained? In the next evaluation stages, the evaluation team will investigate how and whether the new communication technologies are bridging the digital divide and affecting service user feedback.

Evaluation Question 3: COVID-19 Pandemic Impacts

What is not widely known is that "People with pre-existing mental health conditions have the same risk as those with pre-existing noncommunicable diseases (NCDs) of falling ill with and dying of COVID" (WHO meeting June 12, 2021).

As the MHPSS advisors observed, several recent epidemics (COVID-19, SARS, MERS, Ebola, Zika, measles, etc.) had already significantly increased MHPSS risks for PoCs, who often inhabit crowded conditions without adequate sanitation, clean water, and/or access to comprehensive health services. One advisor reported that the Ugandan government, having had to adopt protective measures to isolate refugees from the Democratic Republic of the Congo coming across the border with Ebola, was better prepared than other governments at the start of COVID-19 with contact tracing, temperature controls, and handwashing stations already in place.[9]

The COVID-19 pandemic accentuated and elevated MHPSS risks globally as countries restricted population movements, hosted refugees and IDPs for longer periods, denied asylum and refugee status, and refouled or turned back others at the border, who then risked further harm. The pandemic also overburdened national health care systems, decreased, and halted educational access, and led to the loss of traditional protection mechanisms, all of which have been essential to ensuring integrated MHPSS services and family

and community support. Many refugees and IDPs lost jobs and livelihoods, and those living in squatter settlements (versus established communities and camps) sometimes found themselves out on the street with no place to shelter. Some PoCs dependent on prescription drugs could not obtain critical supplies, which put into question pharmaceutical treatment regimes.

Globally, people suffered employment losses. Frontline workers were at higher risk of contracting COVID-19. Many PoCs continued to work in the informal sector, increasing their health risk. Others uprooted and, on the move seeking shelter, food, safety, and health care, could not find new employment. Waiting time increases and stoppages for asylum decisions also had an impact on PoCs' mental health and ability to continue work activities and small businesses. These disruptions increased the mental health burden for PoCs.

What is not widely known is that "People with pre-existing mental health conditions have the same risk as those with pre-existing noncommunicable diseases (NCDs) of falling ill with and dying of COVID" (WHO meeting, December 6, 2021). Marginalized populations also have higher COVID-19 prevalence and other serious disease morbidity and mortality. Although not yet measured, the most immediate, serious impact of the pandemic for PoCs was increased morbidity, "long COVID," and mortality. These pandemic realities underscored the importance of continuing to address basic human needs (food, shelter, medical care) with MHPSS support.

Evaluation Question 3.1 Partner Adaptations and Factors that Facilitated Adaptations

Adjusting to the pandemic required the NGOs, CBOs, and IOs to address an increased caseload at a distance and, often, virtually (cited in consultations in November 2021).

Major depressive and anxiety disorders were reported as the main reasons for the increase in caseloads. Even though refugee and migrant-specific epidemiological data may be lacking (WHO Consultation December 6, 2021), these reports confirm global findings. A *Lancet* literature review found that anxiety disorders were less than 9.7 percent for countries with

relatively few COVID-19 cases (such as New Zealand and Mongolia) but greater than or equal to 36.4 percent in countries with major caseloads (such as Egypt and Colombia). The *Lancet* review found that women and young adults were disproportionately affected, which is also reported by the IOs and NGO MHPSS managers. The reviewers admit that low-income countries and other mental health impacts are under-represented in these studies.

Evaluation Question 3.2 Changed Understanding of Best Practices in Light of the Pandemic

Given the likelihood of new pandemics, increased population movements from climate change, and further conflict in many regions, societal MHPSS capacity to provide care and support needs to be scaled.

Going local

After the initial disruption, many of the PRM-funded IOs and NGOs (funded from 2020 onwards) reported turning more frequently to trained workers and staff within PoC communities to provide services. Where there was good network coverage, they used Zoom and other meeting technologies to provide online counseling and supervision. They also reported training more PoC community leaders, staff, and volunteers in providing PFA and other support, who, in turn, organized small group meetings.

Using different tools and technologies to address more people at convenient times and with privacy

Providing online counseling sessions had several advantages; for example, there could be more privacy and flexibility, which was particularly important for mothers with children. The counselors could also handle intake and referrals more quickly and waiting times decreased. At the same time, caseload increases and long hours led to staff burnout.

Recognizing the importance of engaging and supporting caregivers

With schools closed, UNICEF and several NGOs reported developing online educational services. They also supported parents in delivering new curricula and addressed their welfare in face of the multiple demands on parents and other caregivers. They developed radio programming so children could continue learning at home and work independently and IOM, UNICEF, and NGOs reported delivering curriculum packages to households.

Training all people in PFA for self-care and support to others

The PFA training was provided to many different service user groups, staff, and volunteers (including ICRC Movement staff and volunteers). Ironically, this training should probably have been disseminated far more widely in Western Europe and North America, because the MHPSS impact was global.

Staff support, training, and supervision

Many MHPSS programs had to lay off staff and/or cut back on hours. Others proudly reported that they kept their staff and work going online. At the same time, those who continued working online observed high levels of burnout, stress, and secondary trauma. With successive waves, one Senior Manager reports, “people are suffering from virtual engagement fatigue” and are “struggling to be relevant and present.” One NGO hired an independent, external psychologist to support its staff and noted that this decision made a difference to staff morale. An IO manager observed that well-educated MHPSS staff members from the capital had more trouble adapting to the changed realities of COVID-19 than the PoCs who were used to having their lives disrupted. One MHPSS lesson learned from COVID-19 was that addressing staff burnout and secondary trauma is critical to maintaining quality care.

Given the likelihood of new pandemics, increased population movements from climate change, and further conflict in many regions, societal MHPSS capacity to provide care and support needs to be scaled (e.g., local MHPSS-trained community volunteers, self-care strategies in school curricula, PFA training) with provider support organized in advance.

Evaluation Question 4: Strengthening PRM's Strategy to Meet and Address Service User Needs

Evaluation Question 4.1 Relevance of Existing MHPSS Strategy to Funding Decisions

The consultations and documents provide extensive evidence that treating specialized mental health and psychological disorders is an essential part of **health programming**. As the MHPSS managers noted, an understanding of the mental health determinants of disease became apparent during the COVID-19 pandemic. The pandemic also increased global awareness that mental health matters.

Several NGO MHPSS advisors observed that there is increasing evidence and recognition that MHPSS is critical to life-saving outcomes in several key sectors and services (shelter, food, WASH, livelihoods). One mentioned that a recent livelihoods program, for example, found that training was not effective if service users were not concurrently provided with MHPSS services. Many women who had lost employment during the pandemic became severely depressed, and even though they had the skills and knowledge, lacked the strength or will to start a new venture. This linkage between sector lifesaving support and MHPSS should be explored further with sector managers and MHPSS staff.

Building local capacity to support communities and address basic PSS is now widely accepted (and reported in the literature, consultations, and PRM portfolio) as requiring a cross-sectoral, systemic approach. That approach is described as increasing community awareness and addressing stigma; identifying, training, and developing local ownership and resources; and building capacity to refer and address acute mental health needs. At the same time, the Evaluation Team should explore further how that is done most effectively in ways that maintain boundaries and do not cause harm. They should also document the role and place for standalone interventions.

Evaluation Question 4.2 Effectiveness of Strategy from-COVID-19 to "Build Back Better"

The pandemic is not over and many PoCs are not vaccinated. They may also still be recovering from the grief and shock of losing family members, friends, livelihoods, communities, and place. The evaluation field research, which is likely to occur amid an ongoing crisis and local emergencies, has the potential to identify some of the MHPSS systems and strategies that are being put in place now that could potentially help to "build back better" for future crises. The evaluation research will be particularly useful if the evaluation team learns from service users and service providers directly what support and coping mechanisms are key to their continued survival and resilience and can concretely advise on what support could make a difference ahead.

Evaluation Question 4.3 Changes and Updates Needed

Recent MHPSS changes and updates relate to addressing staff needs and secondary trauma, making a concerted effort to incorporate MHPSS expertise in PHC systems and national care health systems, and integrating MHPSS expertise and interventions into all emergency programming at the onset of emergencies. As a rapidly changing and evolving field, these and other changes and updates need to be evidenced at all operational levels. These preliminary observations will be tested, amplified, and validated in subsequent evaluation research.

Annex 7: Presenting Qualitative Data

Interview and group data collection capture perspectives of stakeholders in their own words and are useful to inform program interventions in order to understand what key stakeholders think is going well, where they see challenges, what changes they perceive to be occurring as a result of the intervention, and how they view the intervention overall.

Qualitative data can add important context to help program stakeholders learn what needs to be continued or changed about the intervention, increasing chances that the intervention will contribute to desired results. Qualitative data can also add important context to any results emerging from an intervention. If a change is observed, is it due to the design of the intervention? The manner of implementation? Sound management? Or a combination of these (and other factors)? These questions can be answered by capturing others' perspectives though qualitative data. From a program perspective, it is often as useful to understand the 'how' and 'why' questions as it is the binary question of whether a program has caused a result or not.

Interview and focus group data collection are often conducted using semi structured data collection tools. In such tools, important topics and a general question outline are prepared in advance. However, the evaluator has leeway to word the questions and decide on question sequence based on the interview setting. In addition, the evaluator is free to pursue topics that emerge during the interview/focus group that were not anticipated. The benefit to this approach is that data collection is flexible and can be tailored to different data collection settings. The challenge is that analysis is difficult because respondents are not asked the exact same questions in the same sequence.

When analyzing qualitative data captured through semi-structured methods it is incumbent upon the data analysts to identify emerging patterns and themes from the data. Presenting findings using proportions or percentages of respondents is typically not useful if the data are derived from semi-structured or open-ended methods. For example, if data are presented as follows: "24 of 80 respondents felt that the training content was relevant," the reader might wrongly interpret the finding to mean that the majority of respondents felt that the training

content was not relevant, because it could be the case that the majority of respondents were not asked a question specific to the relevance of training content during data collection. Thus, qualitative data analysis depends on the experience and integrity of the data analysts to present the data in a manner that is fair, accurate and useful. This often involves triangulating findings across multiple data sources.

Qualitative data presentation often includes the use of quotes that were captured during data collection. Quotes are included in evaluation reports when they are considered representative of a general theme that emerged through data analysis.

Annex 8: Conflict of Interest Disclosures

Disclosure of Real or Potential Conflict of Interest for DoS Evaluations

Instructions:

Evaluations of U.S. Department of State (DoS) projects will be undertaken so that they are not subject to the perception or reality of biased measurement or reporting due to conflict of interest. For external evaluations, all evaluation team members will provide a signed statement attesting to a lack of conflict of interest or describing an existing conflict of interest relative to the project being evaluated.

Evaluators of DoS projects have a responsibility to maintain independence so that opinions, conclusions, judgments, and recommendations will be impartial and will be viewed as impartial by third parties. Evaluators and evaluation team members are to disclose all relevant facts regarding real or potential conflicts of interest that could lead reasonable third parties with knowledge of the relevant facts and circumstances to conclude that the evaluator or evaluation team member is not able to maintain independence and, thus, is not capable of exercising objective and impartial judgment on all issues associated with conducting and reporting the work. Operating Unit leadership, in close consultation with the Contracting Officer, will determine whether the real or potential conflict of interest is one that should disqualify an individual from the evaluation team or require recusal by that individual from evaluating certain aspects of the project(s).

In addition, if evaluation team members gain access to proprietary information of other companies in the process of conducting the evaluation, then they must agree with the other companies to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Real or potential conflicts of interest may include, but are not limited to:

- Immediate family or close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.

- Financial interest that is direct, or is significant/material though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.

- Current or previous direct or significant/material though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.

- Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.

- Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.

- Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.

Disclosure of Conflict of Interest for DoS Evaluation Team Members

Katherine Batchelder, Monitoring and Evaluation Specialist II

Organization: EnCompass, LLC

Evaluation Position: Team member

Contract Number: D17PC00492

Task Order Number: 140D0421F0739

DOS Projects evaluated include projects from PRM MHPSS Portfolio implemented by the following IOs/NGOs:

- UNHCR
- IOM
- WHO
- ICRC
- UNICEF
- Hebrew Immigrant Aid Society (HIAS)
- International Medical Corp (IMC)
- Center for Victims of Torture (CVT)
- Jesuit Refugee Services (JRS)

Real or potential conflicts of interest may include, but are not limited to:

- Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.

- Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.

- Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.

- Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.

- Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.

- Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.

Do you have a real or potential conflict of interest to disclose?: No

I certify that I have completed this disclosure form fully and to the best of my ability and that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature:

Date: April 22, 2022

Lane Benton, Project Coordinator

Organization: EnCompass, LLC

Evaluation Position: Team member

Contract Number: D17PC00492

Task Order Number: 140D0421F0739

DOS Projects evaluated include projects from PRM MHPSS Portfolio implemented by the following IOs/NGOs:

- UNHCR
- IOM
- WHO
- ICRC
- UNICEF
- Hebrew Immigrant Aid Society (HIAS)
- International Medical Corp (IMC)
- Center for Victims of Torture (CVT)
- Jesuit Refugee Services (JRS)

Real or potential conflicts of interest may include, but are not limited to:

- Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.

- Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.
- Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.
- Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.
- Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.
- Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.

Do you have a real or potential conflict of interest to disclose?: No

I certify that I have completed this disclosure form fully and to the best of my ability and that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature: Lane Benton

Date: 30 November 2021

Lauren Else, MEL Specialist II

Organization: EnCompass, LLC

Evaluation Position: Team member

Contract Number: D17PC00492

Task Order Number: 140D0421F0739

DOS Projects evaluated include projects from PRM MHPSS Portfolio implemented by the following IOs/NGOs:

- UNHCR
- IOM
- WHO
- ICRC
- UNICEF
- Hebrew Immigrant Aid Society (HIAS)
- International Medical Corp (IMC)
- Center for Victims of Torture (CVT)
- Jesuit Refugee Services (JRS)

Real or potential conflicts of interest may include, but are not limited to:

- Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.

- Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.
- Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.
- Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.
- Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.
- Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.

Do you have a real or potential conflict of interest to disclose?: No

I certify that I have completed this disclosure form fully and to the best of my ability and that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature:

Date: 12/6/21

Sara Ahmaz, Subject Matter Expert (consultant)

Organization: EnCompass, LLC

Evaluation Position: Team member

Contract Number: D17PC00492

Task Order Number: 140D0421F0739

DOS Projects evaluated include projects from PRM MHPSS Portfolio implemented by the following IOs/NGOs:

- UNHCR
- IOM
- WHO
- ICRC
- UNICEF
- Hebrew Immigrant Aid Society (HIAS)
- International Medical Corp (IMC)
- Center for Victims of Torture (CVT)
- Jesuit Refugee Services (JRS)

Real or potential conflicts of interest may include, but are not limited to:

- Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.

- Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.
- Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.
- Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.
- Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.
- Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.

Do you have a real or potential conflict of interest to disclose?: Yes, I am currently working as a consultant for UNICEF.

I certify that I have completed this disclosure form fully and to the best of my ability and that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature: Sara Amhaz

Date: 04/12/21

Gayatri Malhotra, MEL Specialist I

Organization: EnCompass, LLC

Evaluation Position: Team member

Contract Number: D17PC00492

Task Order Number: 140D0421F0739

DOS Projects evaluated include projects from PRM MHPSS Portfolio implemented by the following IOs/NGOs:

- UNHCR
- IOM
- WHO
- ICRC
- UNICEF
- Hebrew Immigrant Aid Society (HIAS)
- International Medical Corp (IMC)
- Center for Victims of Torture (CVT)
- Jesuit Refugee Services (JRS)

Real or potential conflicts of interest may include, but are not limited to:

- Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.

- Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.
- Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.
- Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.
- Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.
- Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.

Do you have a real or potential conflict of interest to disclose?: No

I certify that I have completed this disclosure form fully and to the best of my ability and that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature:

Date: 2/15/22

Alfred Theodore Rizzo, MEL Specialist II

Organization: EnCompass, LLC

Evaluation Position: Team member

Contract Number: D17PC00492

Task Order Number: 140D0421F0739

DOS Projects evaluated include projects from PRM MHPSS Portfolio implemented by the following IOs/NGOs:

- UNHCR
- IOM
- WHO
- ICRC
- UNICEF
- Hebrew Immigrant Aid Society (HIAS)
- International Medical Corp (IMC)
- Center for Victims of Torture (CVT)
- Jesuit Refugee Services (JRS)

Real or potential conflicts of interest may include, but are not limited to:

- Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.

- Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.
- Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.
- Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.
- Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.
- Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.

Do you have a real or potential conflict of interest to disclose?: No

I certify that I have completed this disclosure form fully and to the best of my ability and that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature: Alfred T Rizzo

Date: 2/15/22

Jonathan Jones, Director of Technical Assistance and Evaluation

Organization: EnCompass, LLC

Evaluation Position: Team member

Contract Number: D17PC00492

Task Order Number: 140D0421F0739

DOS Projects evaluated include projects from PRM MHPSS Portfolio implemented by the following IOs/NGOs:

- UNHCR
- IOM
- WHO
- ICRC
- UNICEF
- Hebrew Immigrant Aid Society (HIAS)
- International Medical Corp (IMC)
- Center for Victims of Torture (CVT)
- Jesuit Refugee Services (JRS)

Real or potential conflicts of interest may include, but are not limited to:

- Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.

- Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.

- Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.

- Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.

- Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.

- Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.

Do you have a real or potential conflict of interest to disclose?: No

I certify that I have completed this disclosure form fully and to the best of my ability and that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature:

Date: 2/15/22

Lynellyn Long, Evaluation Team Lead (consultant)

Organization: EnCompass, LLC

Evaluation Position: Team Lead

Contract Number: D17PC00492

Task Order Number: 140D0421F0739

DOS Projects evaluated include projects from PRM MHPSS Portfolio implemented by the following IOs/NGOs:

- UNHCR
- IOM
- WHO
- ICRC
- UNICEF
- Hebrew Immigrant Aid Society (HIAS)
- International Medical Corp (IMC)
- Center for Victims of Torture (CVT)
- Jesuit Refugee Services (JRS)

Real or potential conflicts of interest may include, but are not limited to:

- Close family member who is an employee of the DoS operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.

- Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.
- Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.
- Current or previous work experience or seeking employment with the DoS operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.
- Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.
- Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.

Do you have a real or potential conflict of interest to disclose?: No

I certify that I have completed this disclosure form fully and to the best of my ability and that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Lavellyn D Long
Date	12/1/21

Annex 9: Additional Survey Charts

Table 18: Supporting data table for Exhibit 2 – The extent to which NGOs shifted MHPSS programming resources and attention to respond to the pandemic (n=25)

Issue	Moderately or Significantly	Not at all	Don't know	Prefer not to say	Not applicable
Increase in IPV	88%	0%	4%	0%	8%
Increase in SGBV incidents	85%	4%	8%	0%	4%
Insufficient Food Supplies and deliveries	68%	20%	8%	0%	4%
Lack of Access to Educational Services	70%	19%	4%	0%	7%
Lack of access to persons without internet	56%	20%	8%	0%	16%
Less access with over-burdened medical services	64%	20%	4%	0%	12%
Long-term COVID health impacts	52%	32%	4%	0%	12%
Loss of housing or shelter	64%	20%	0%	0%	16%
Loss of Livelihoods	76%	12%	0%	0%	12%

[Return to Exhibit 2]

Exhibit 4: MHPSS services that have been provided using PRM-funding and if the services have been stand-alone or integrated through a sector program

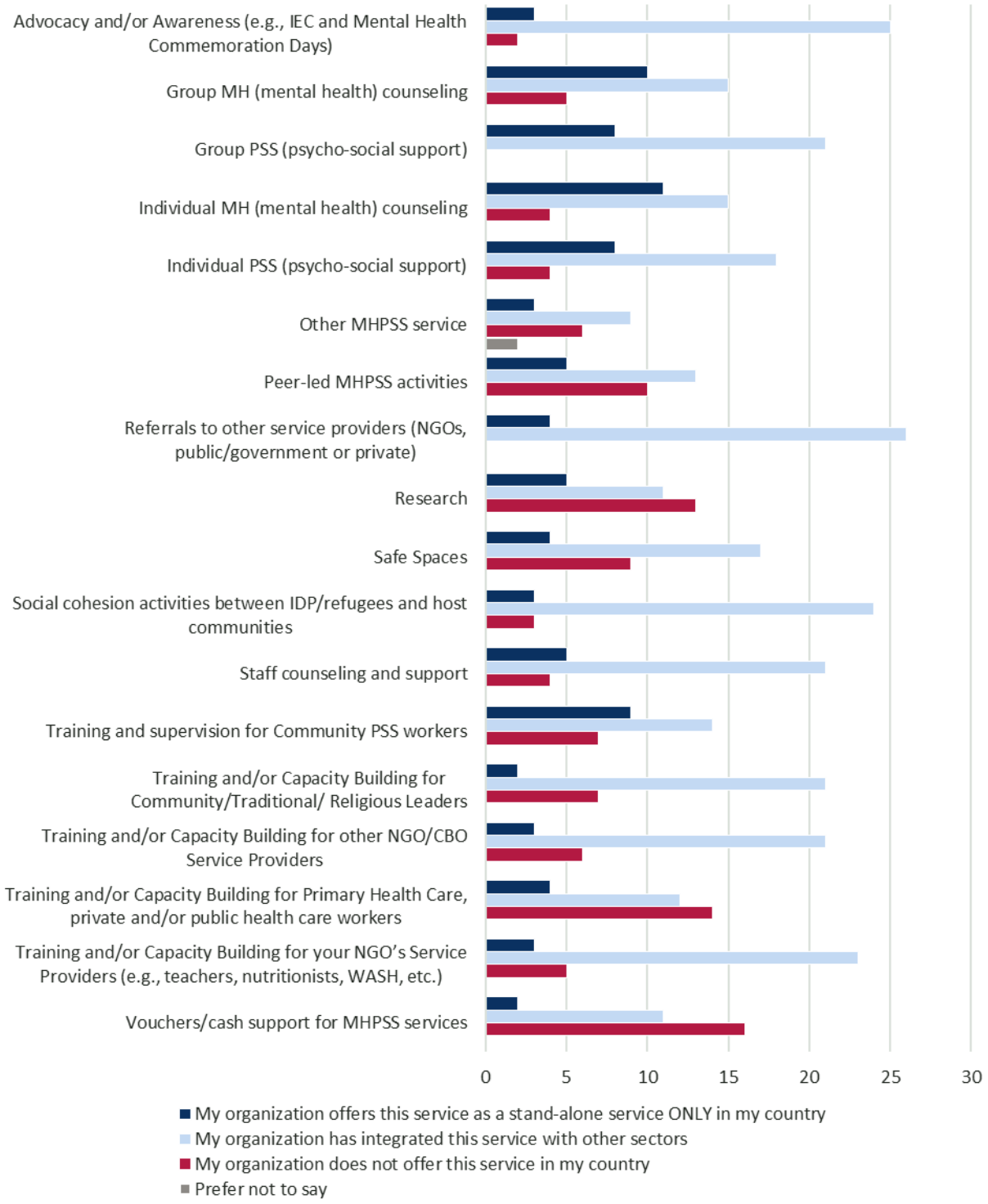


Table 19: Supporting data table for Exhibit 4 – MHPSS services that have been provided using PRM-funding and if the services have been stand-alone or integrated through a sector program

Type of Service/Intervention	Prefer not to say	My organization does not offer this service in my country	My organization has integrated this service with other sectors	My organization offers this service as a stand-alone service ONLY in my country
Advocacy and/or Awareness (e.g., IEC and Mental Health Commemoration Days)	0	2	25	3
Group MH (mental health) counseling	0	5	15	10
Group PSS (psycho-social support)	0	0	21	8
Individual MH (mental health) counseling	0	4	15	11
Individual PSS (psycho-social support)	0	4	18	8
Other MHPSS service	2	6	9	3
Peer-led MHPSS activities	0	10	13	5
Referrals to other service providers (NGOs, public/government or private)	0	0	26	4
Research	0	13	11	5
Safe Spaces	0	9	17	4
Social cohesion activities between IDP/refugees and host communities	0	3	24	3
Staff counseling and support	0	4	21	5

Type of Service/Intervention	Prefer not to say	My organization does not offer this service in my country	My organization has integrated this service with other sectors	My organization offers this service as a stand-alone service ONLY in my country
Training and supervision for Community PSS workers	0	7	14	9
Training and/or Capacity Building for Community/Traditional/ Religious Leaders	0	7	21	2
Training and/or Capacity Building for other NGO/CBO Service Providers	0	6	21	3
Training and/or Capacity Building for Primary Health Care, private and/or public health care workers	0	14	12	4
Training and/or Capacity Building for your NGO's Service Providers (e.g., teachers, nutritionists, WASH, etc.)	0	5	23	3
Vouchers/cash support for MHPSS services	0	16	11	2

Table 20: Supporting data table for Exhibits 5 through 9 – MHPSS Services identified in Exhibit 4 that have been integrated into MHPSS programs

Services	Protection programs	Education programs	GBV programs	Health programs	WASH programs
Advocacy and/or awareness (e.g., IEC and mental health commemoration days)	23	10	15	15	2
Group MH (mental health) counseling	14	5	9	5	0
Group PSS (psycho-social support)	20	7	10	7	0
Individual MH (mental health) counseling	12	5	8	8	0
Individual PSS (psycho-social support)	16	6	10	7	0
Other (response repeated from above)	6	2	3	4	1
Peer-led MHPSS activities	12	4	5	3	1
Referrals to other service providers (NGOs, public/government or private)	20	13	13	13	7
Research	6	3	3	5	1
Safe Spaces	13	8	7	6	1
Social cohesion activities between IDP/refugees and host communities	19	8	11	8	2
Staff counseling and support	15	7	8	7	3
Training and supervision for community PSS workers	13	5	6	4	1
Training and/or capacity building for community/ traditional/ religious leaders	17	6	9	9	2
Training and/or capacity building for other NGO/CBO service providers	16	9	10	10	1
Training and/or capacity building for primary health care, private and/or public health care workers	6	2	3	6	1

Services	Protection programs	Education programs	GBV programs	Health programs	WASH programs
Training and/or capacity building for your NGO's service providers (e.g., teachers, nutritionists, WASH, etc.)	16	6	9	11	1
Vouchers/cash support for MHPSS services	7	1	3	2	0

Exhibit 5: MHPSS Services identified in Exhibit 4 that have been integrated into MHPSS Protection programs

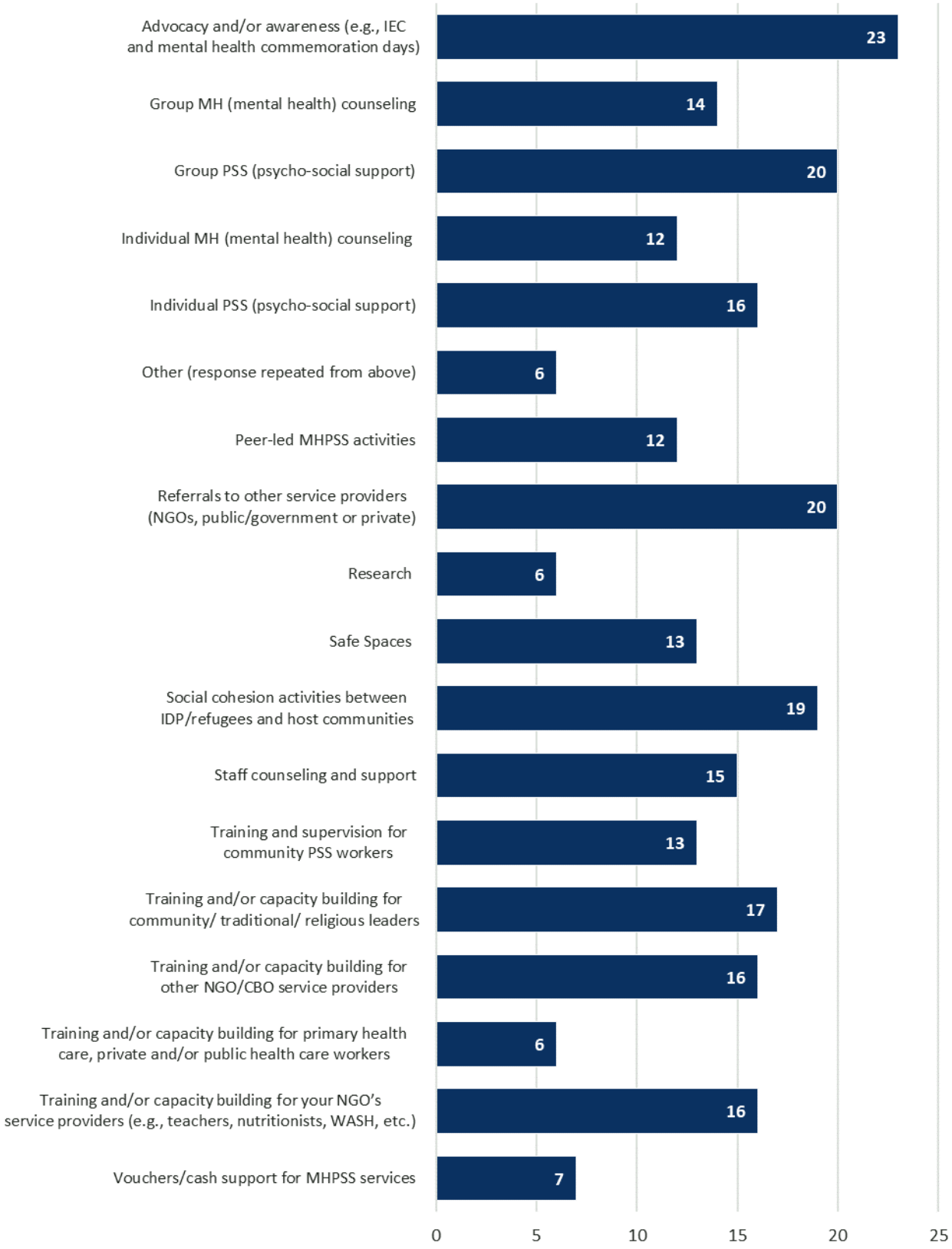


Exhibit 6: MHPSS Services identified in Exhibit 4 that have been integrated into MHPSS Education programs

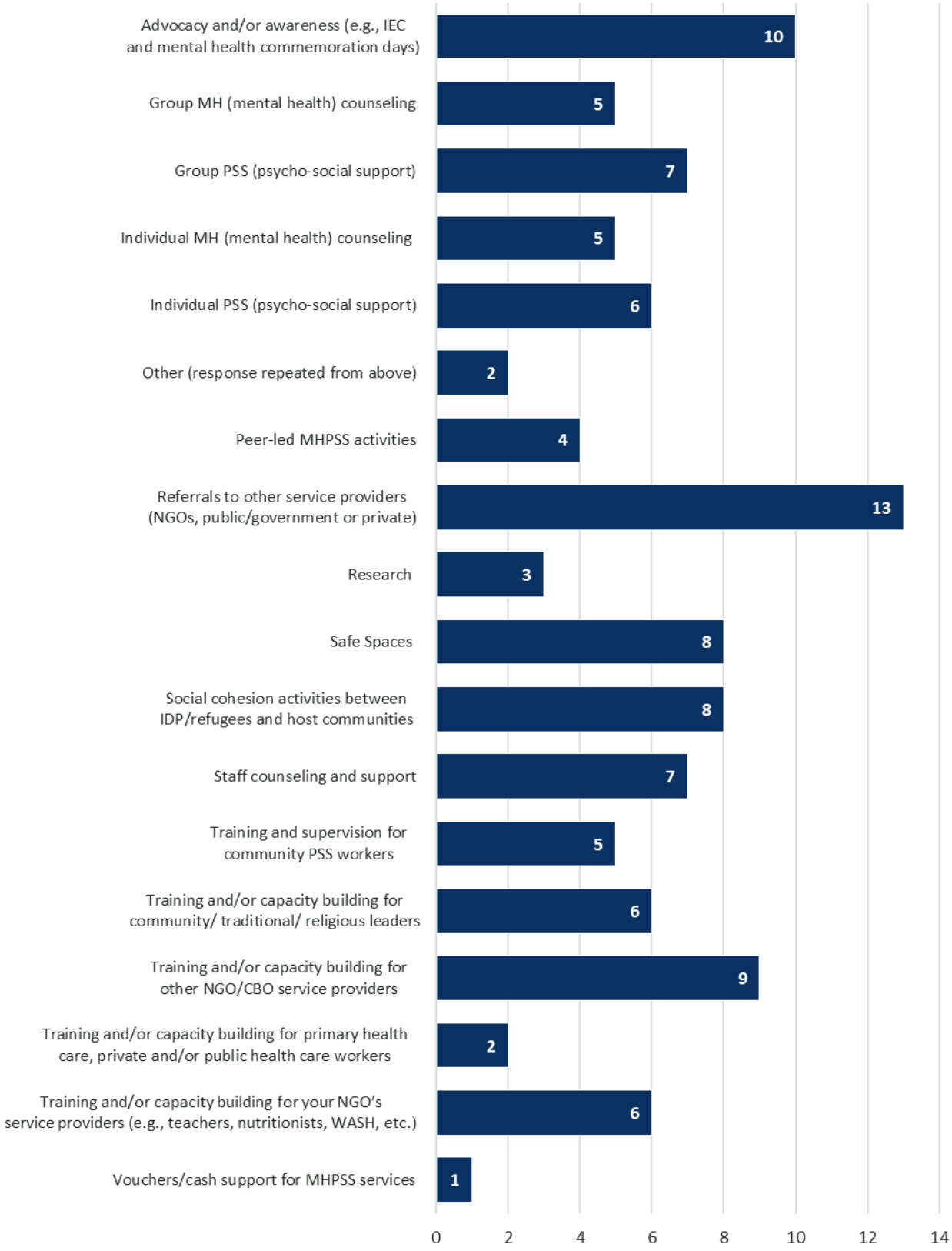


Exhibit 7: MHPSS Services identified in Exhibit 4 that have been integrated into MHPSS GBV programs

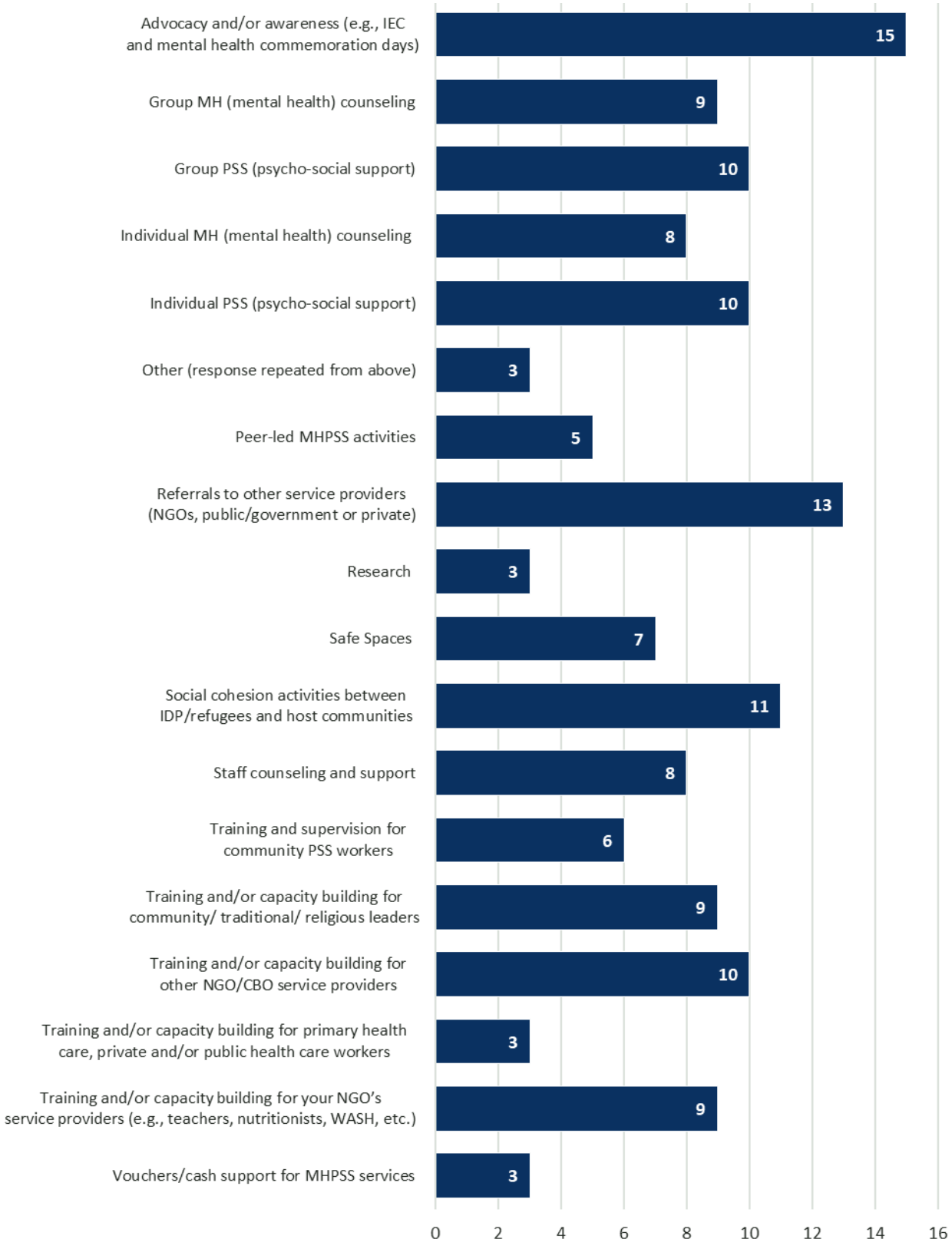


Exhibit 8: MHPSS Services identified in Exhibit 4 that have been integrated into MHPSS Health programs

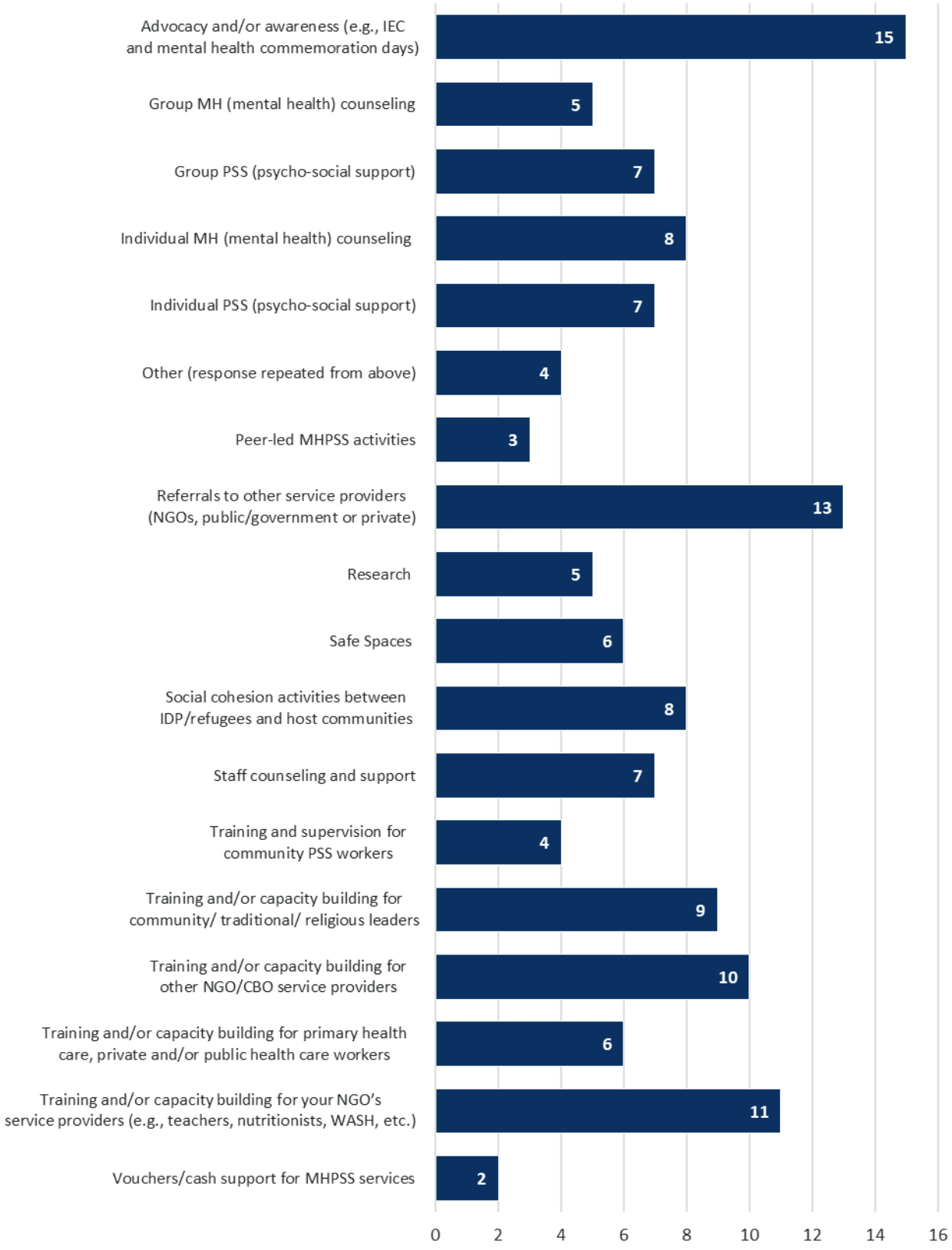


Exhibit 9: MHPSS Services identified in Exhibit 4 that have been integrated into MHPSS WASH programs

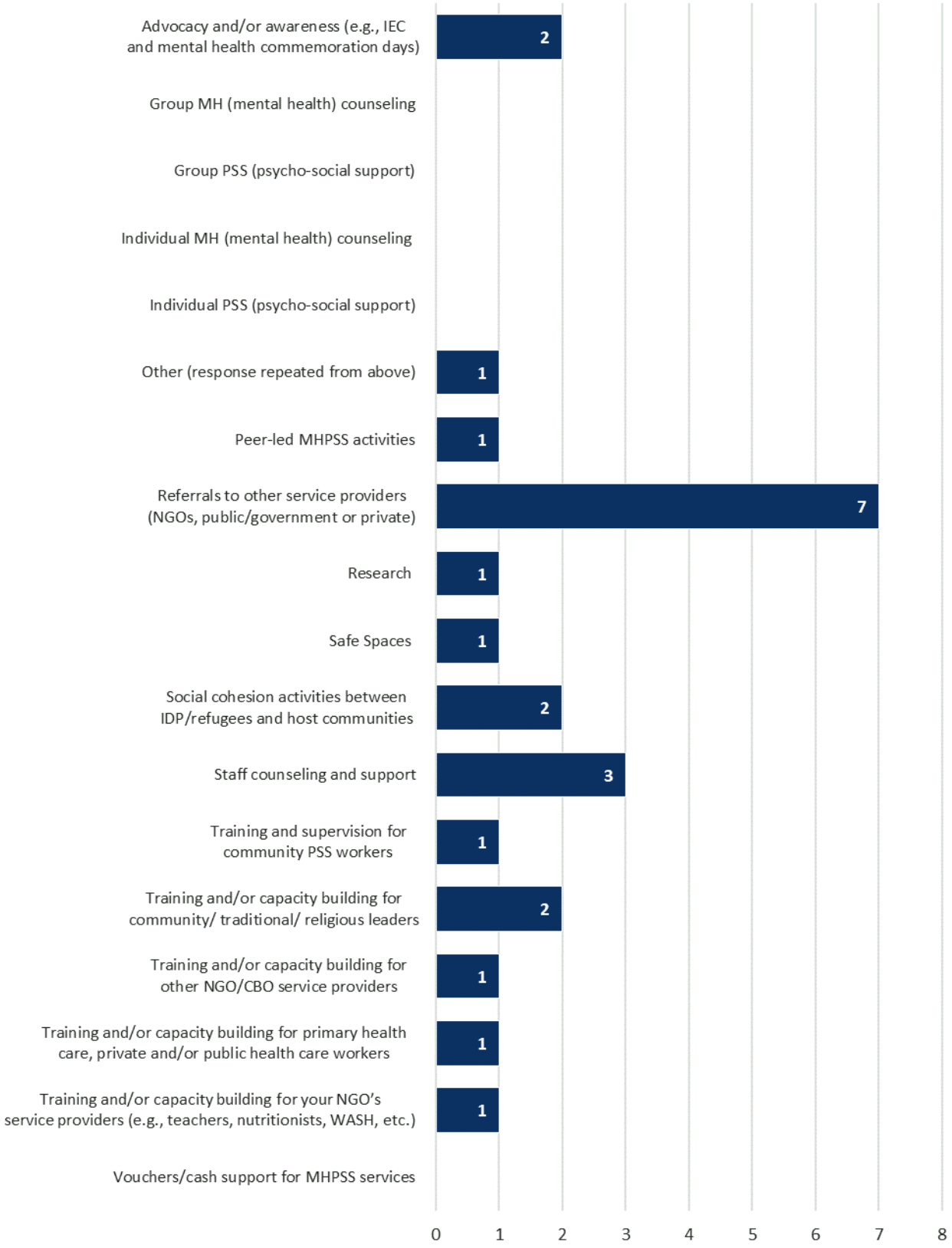


Exhibit 10: Therapies that have been used for individuals, groups, or both in PRM funded programming

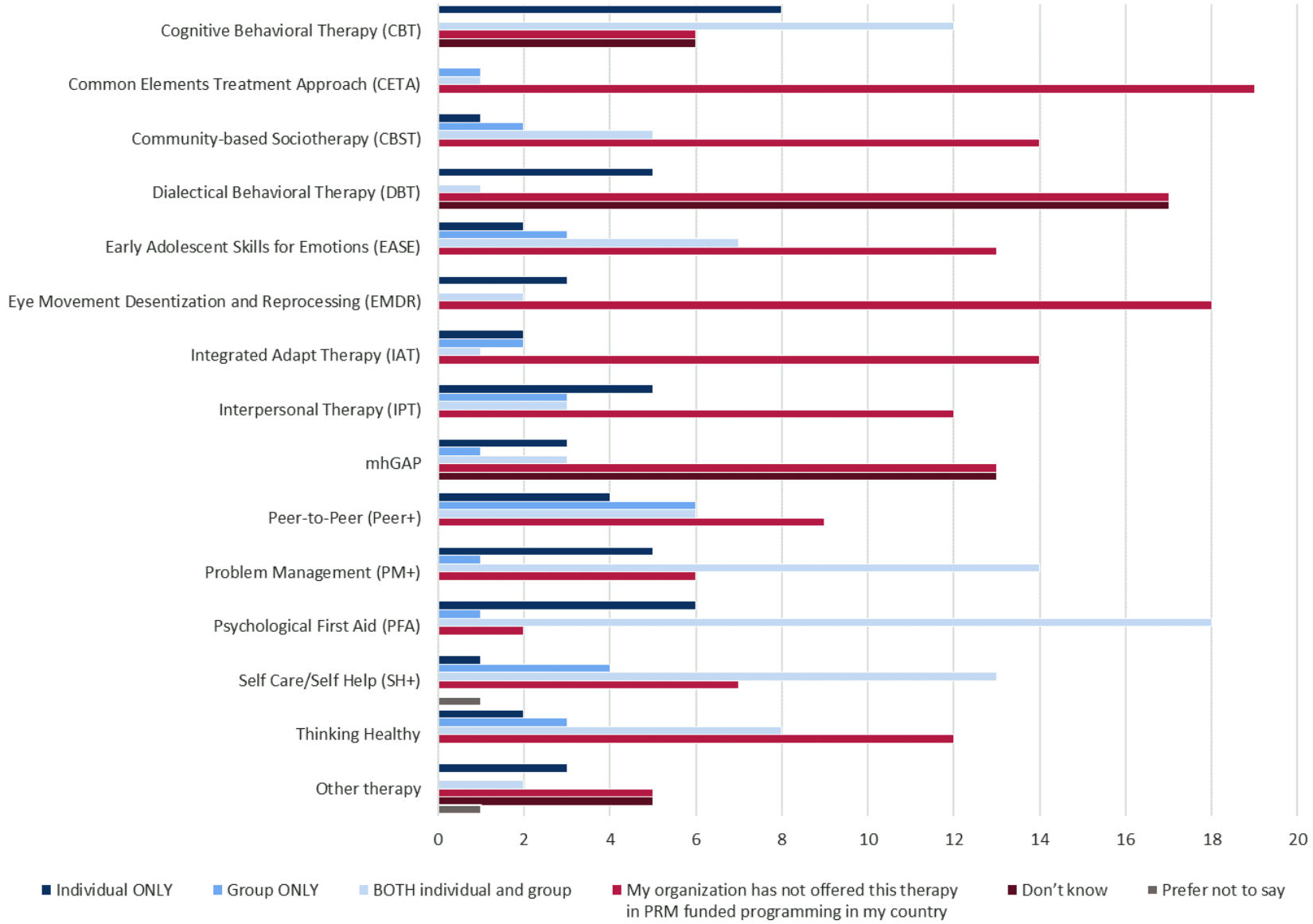


Table 21: Supporting data table for Exhibit 10 – Therapies that have been used for individuals, groups, or both in PRM funded programming

Therapy	Individual ONLY	Group ONLY	BOTH individual and group	My organization has not offered this therapy in PRM funded programming in my country	Don't know	Prefer not to say
Cognitive Behavioral Therapy (CBT)	8	0	12	6	6	0
Common Elements Treatment Approach (CETA)	0	1	1	19	0	0
Community-based Sociotherapy (CBST)	1	2	5	14	0	0
Dialectical Behavioral Therapy (DBT)	5	0	1	17	17	0
Early Adolescent Skills for Emotions (EASE)	2	3	7	13	0	0
Eye Movement Desentization and Reprocessing (EMDR)	3	0	2	18	0	0
Integrated Adapt Therapy (IAT)	2	2	1	14	0	0
Interpersonal Therapy (IPT)	5	3	3	12	0	0
mhGAP	3	1	3	13	13	0

Therapy	Individual ONLY	Group ONLY	BOTH individual and group	My organization has not offered this therapy in PRM funded programming in my country	Don't know	Prefer not to say
Peer-to-Peer (Peer+)	4	6	6	9	0	0
Problem Management (PM+)	5	1	14	6	0	0
Psychological First Aid (PFA)	6	1	18	2	0	0
Self Care/Self Help (SH+)	1	4	13	7	0	1
Thinking Healthy	2	3	8	12	0	0
Other therapy	3	0	2	5	5	1

Exhibit 11: Therapies offered to Refugees in Camps as part of PRM-funded MHPSS programming

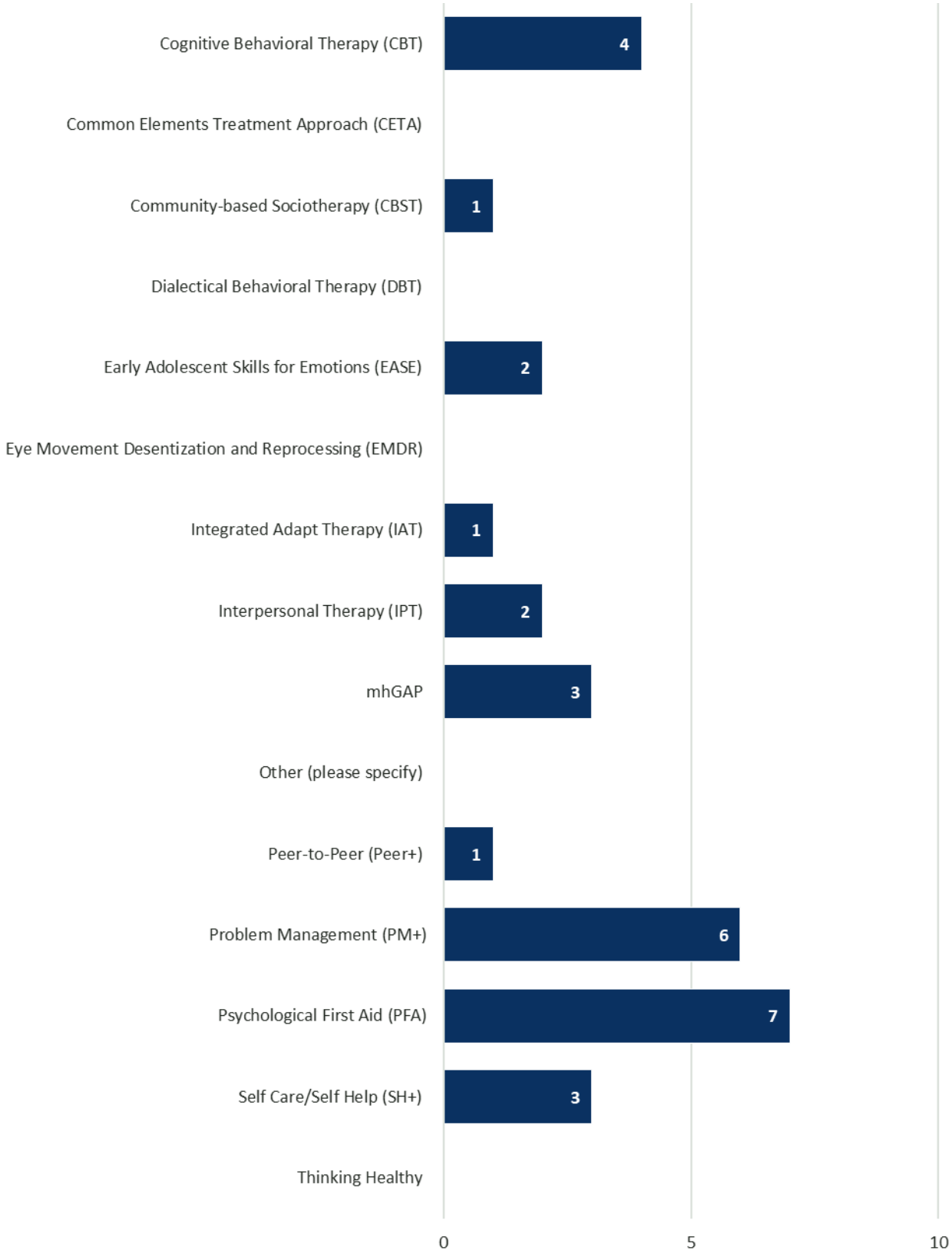


Exhibit 12: Therapies offered to Refugees Outside of Camps as part of PRM-funded MHPSS programming

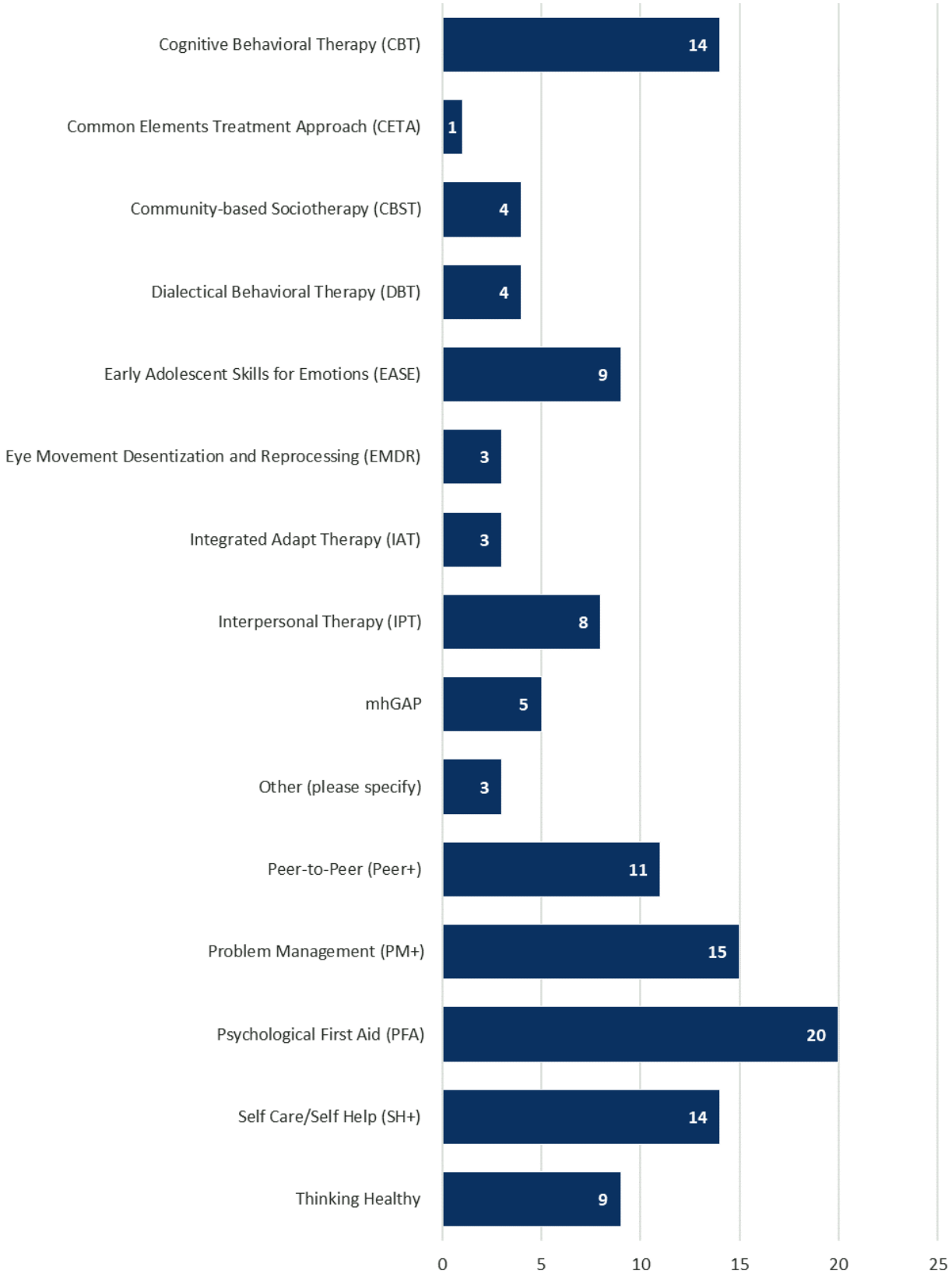


Exhibit 13: Therapies offered to Internally Displaced Persons as part of PRM-funded MHPSS programming

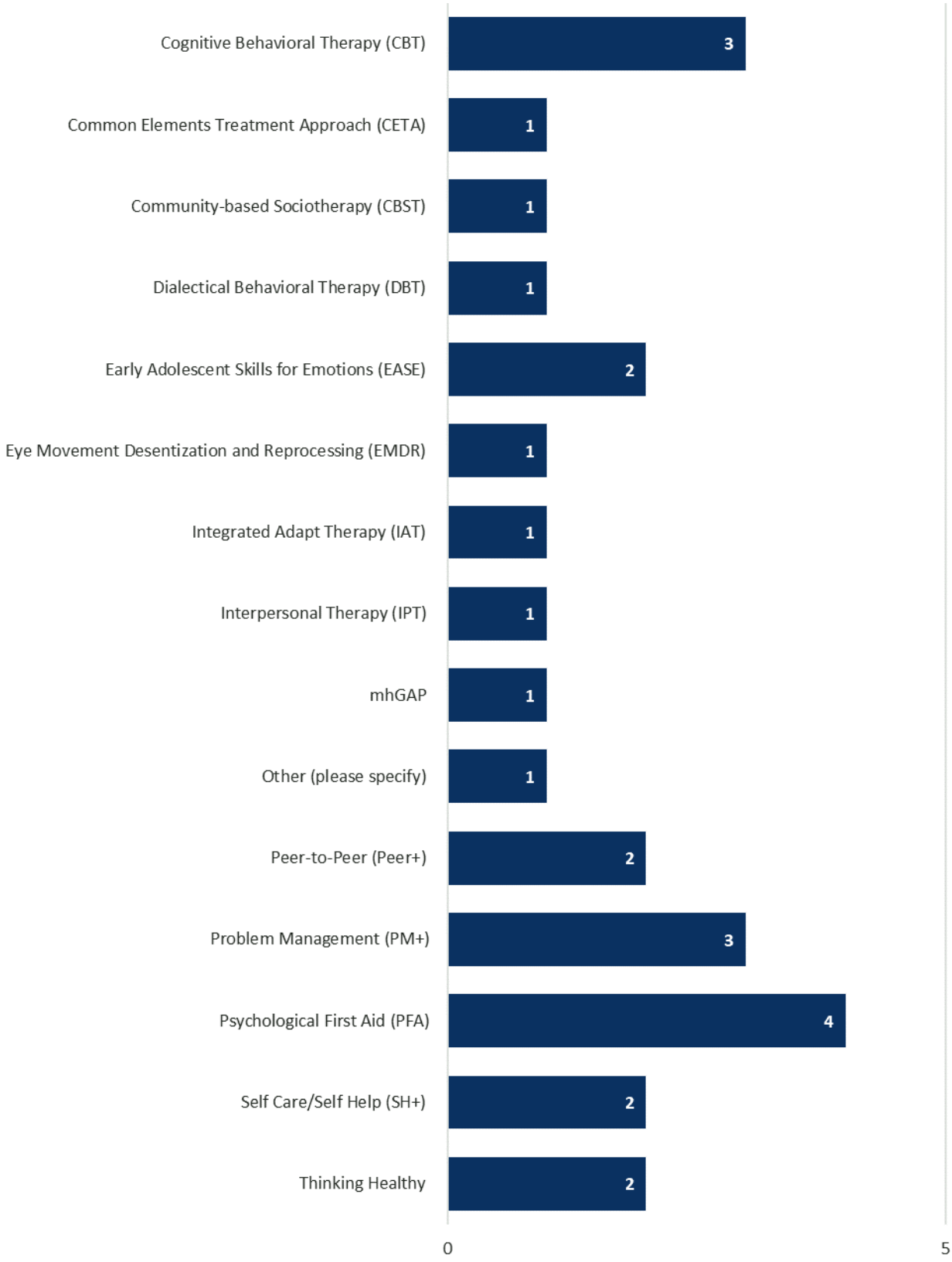


Exhibit 14: Therapies offered to Stateless People as part of PRM-funded MHPSS programming

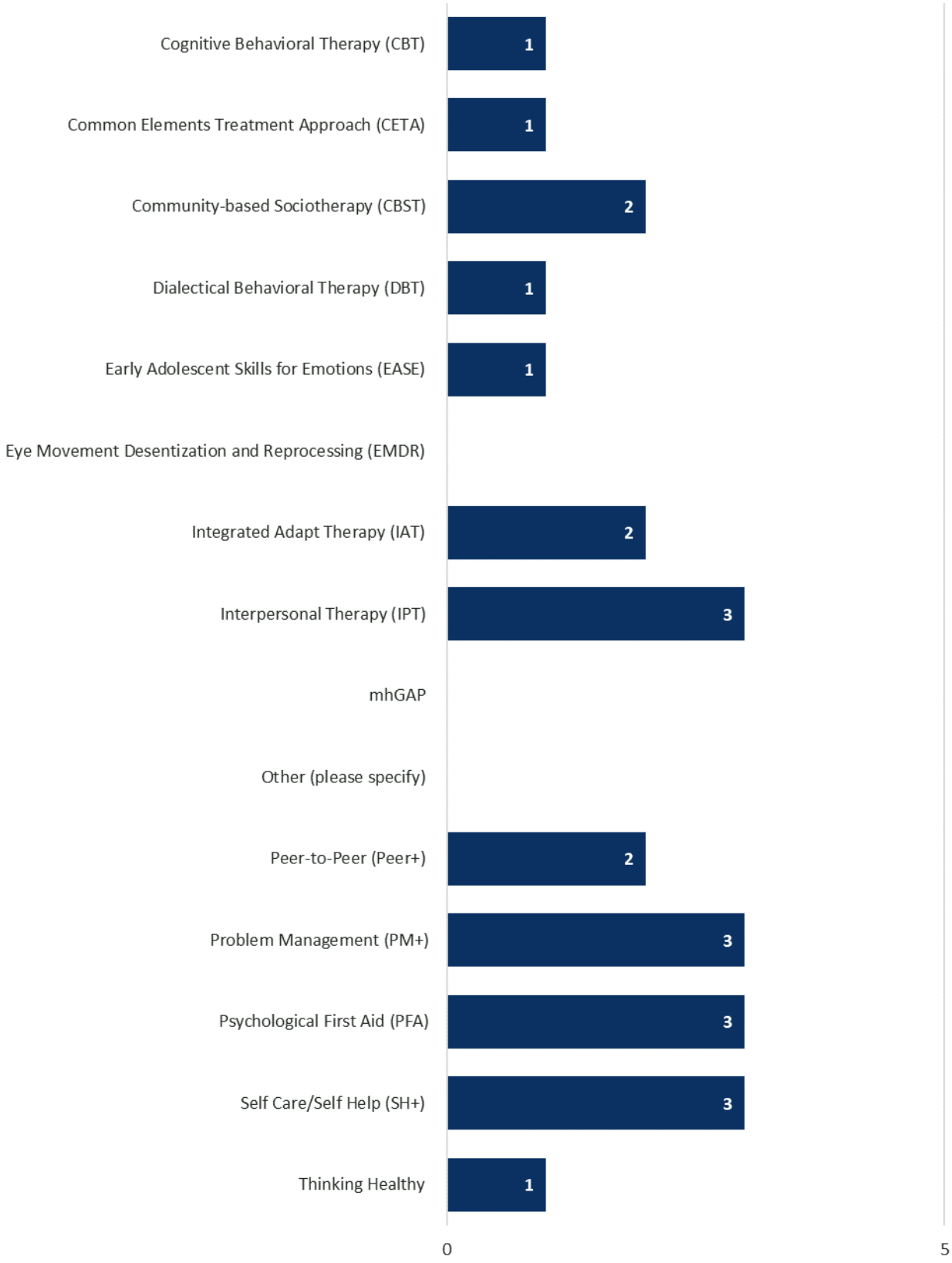


Exhibit 15: Therapies offered to Returnees as part of PRM-funded MHPSS programming

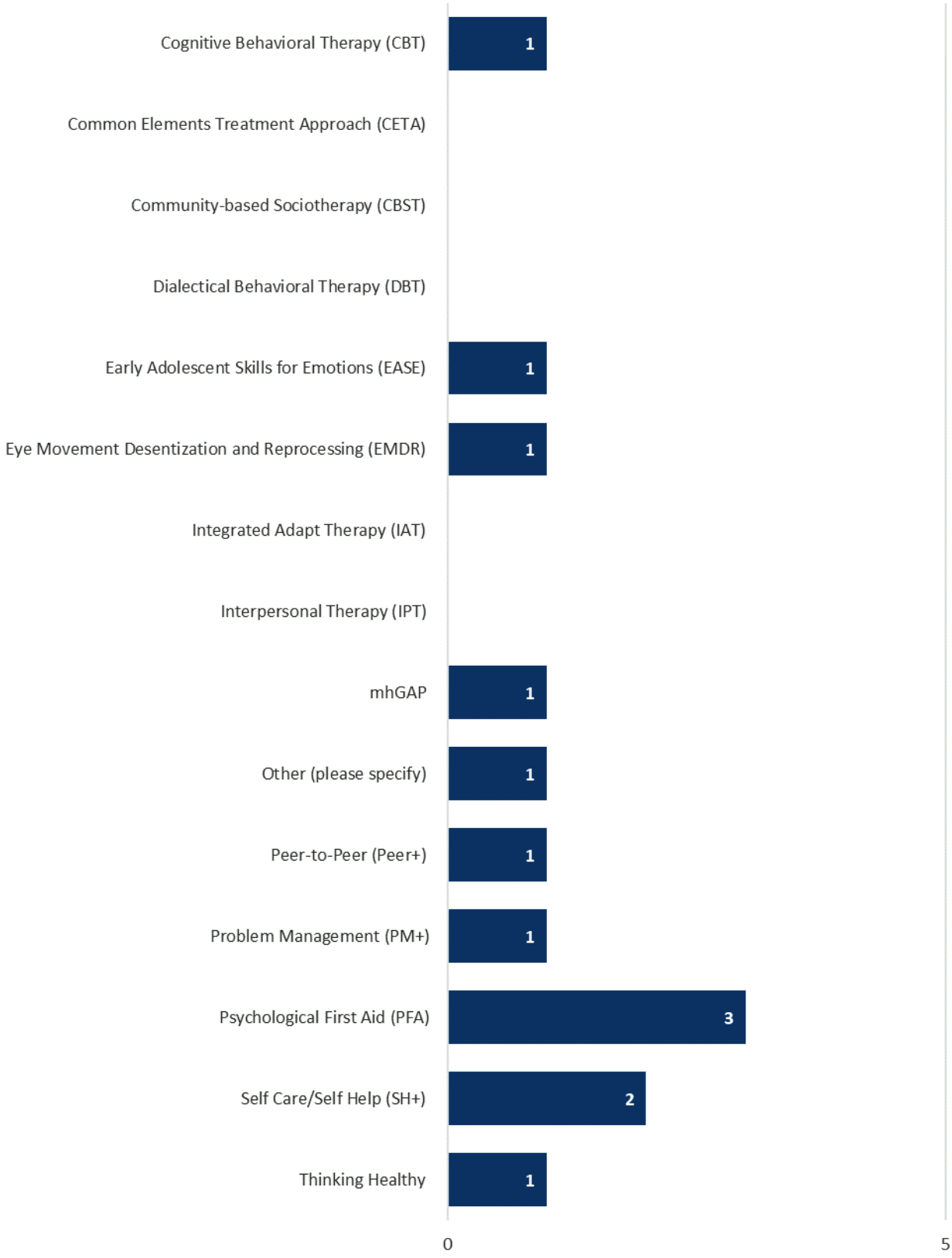


Exhibit 16: Therapies offered to Asylum Seakers as part of PRM-funded MHPSS programming

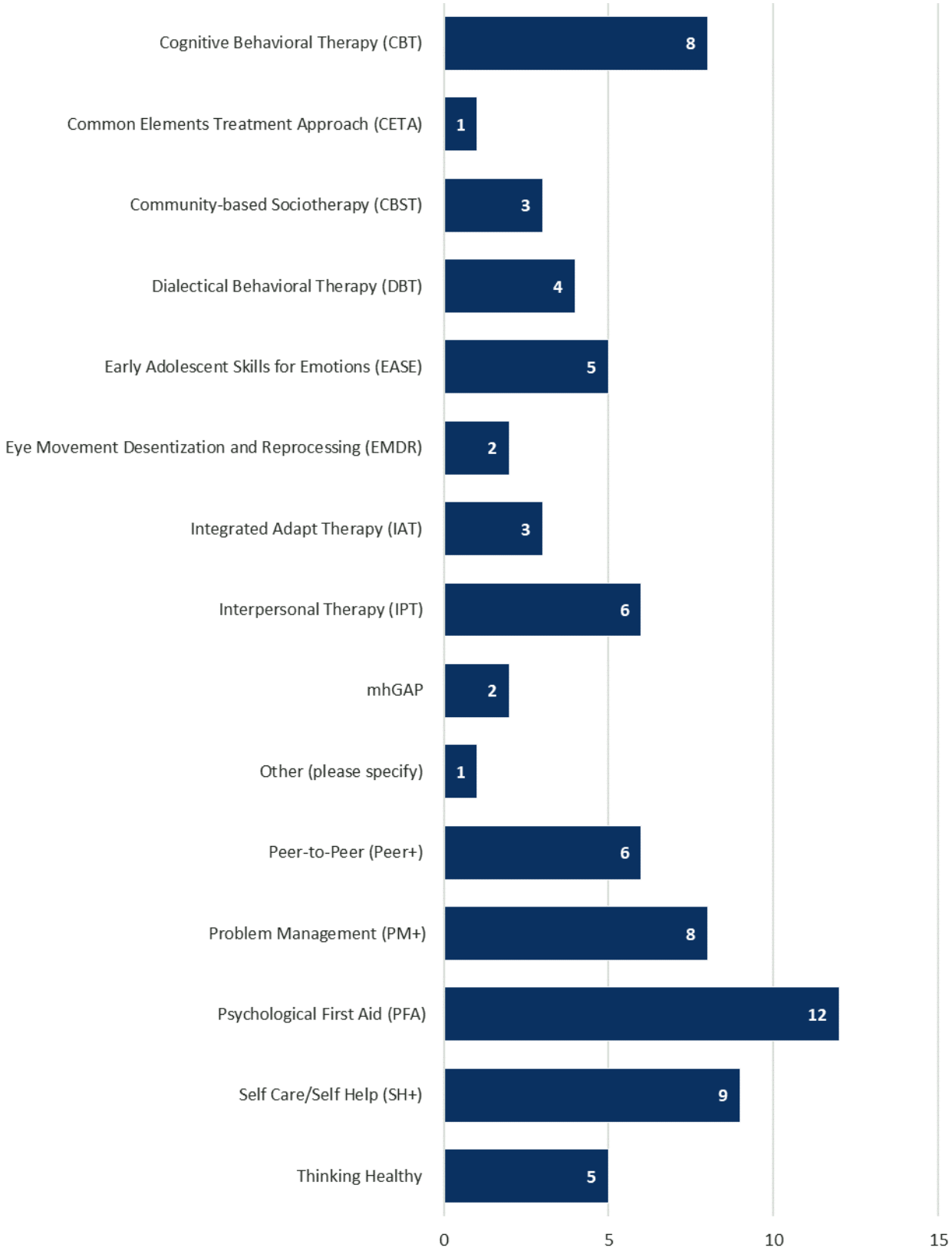


Exhibit 17: Therapies offered to Migrants as part of PRM-funded MHPSS programming

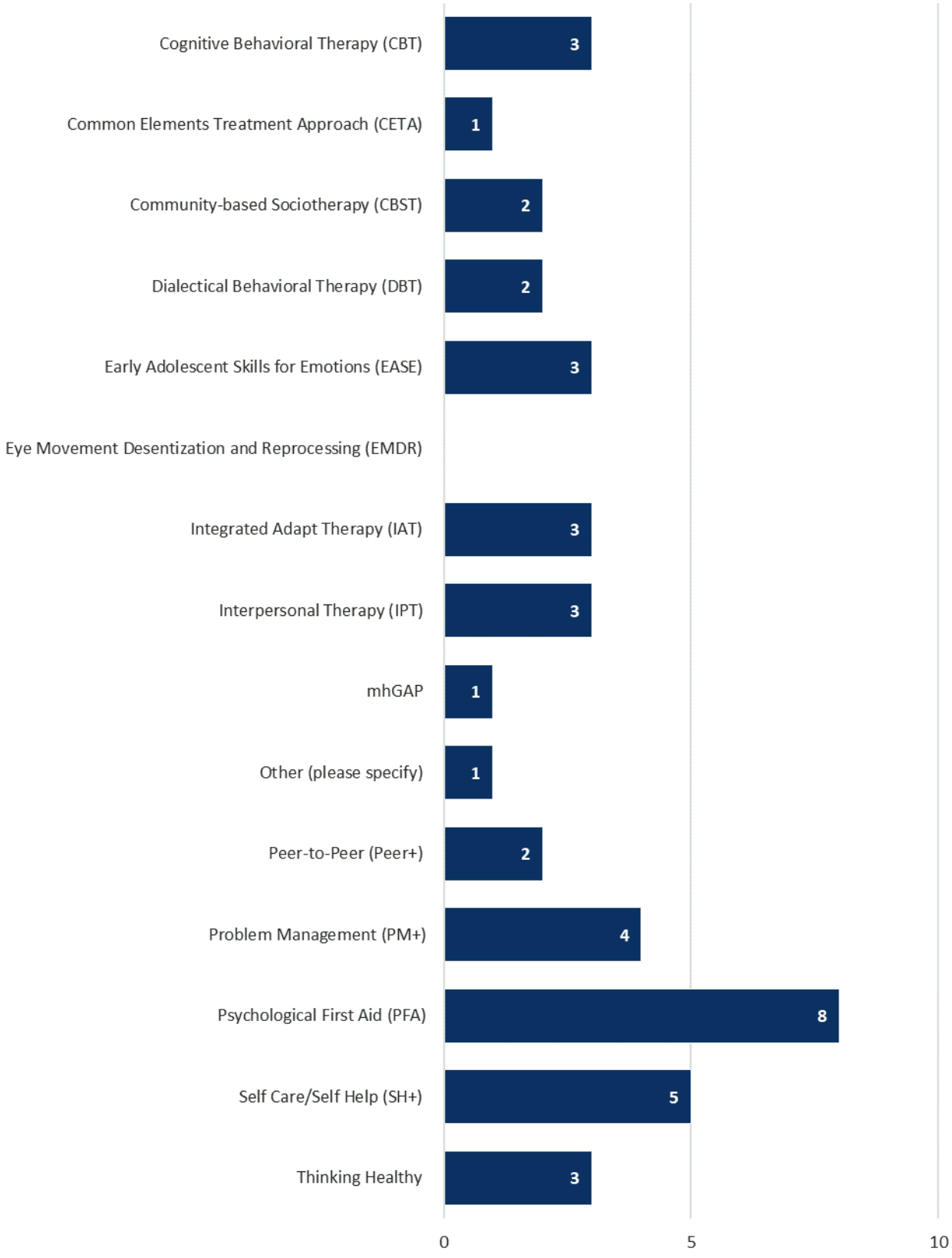


Exhibit 18: Therapies offered to Local Communities as part of PRM-funded MHPSS programming

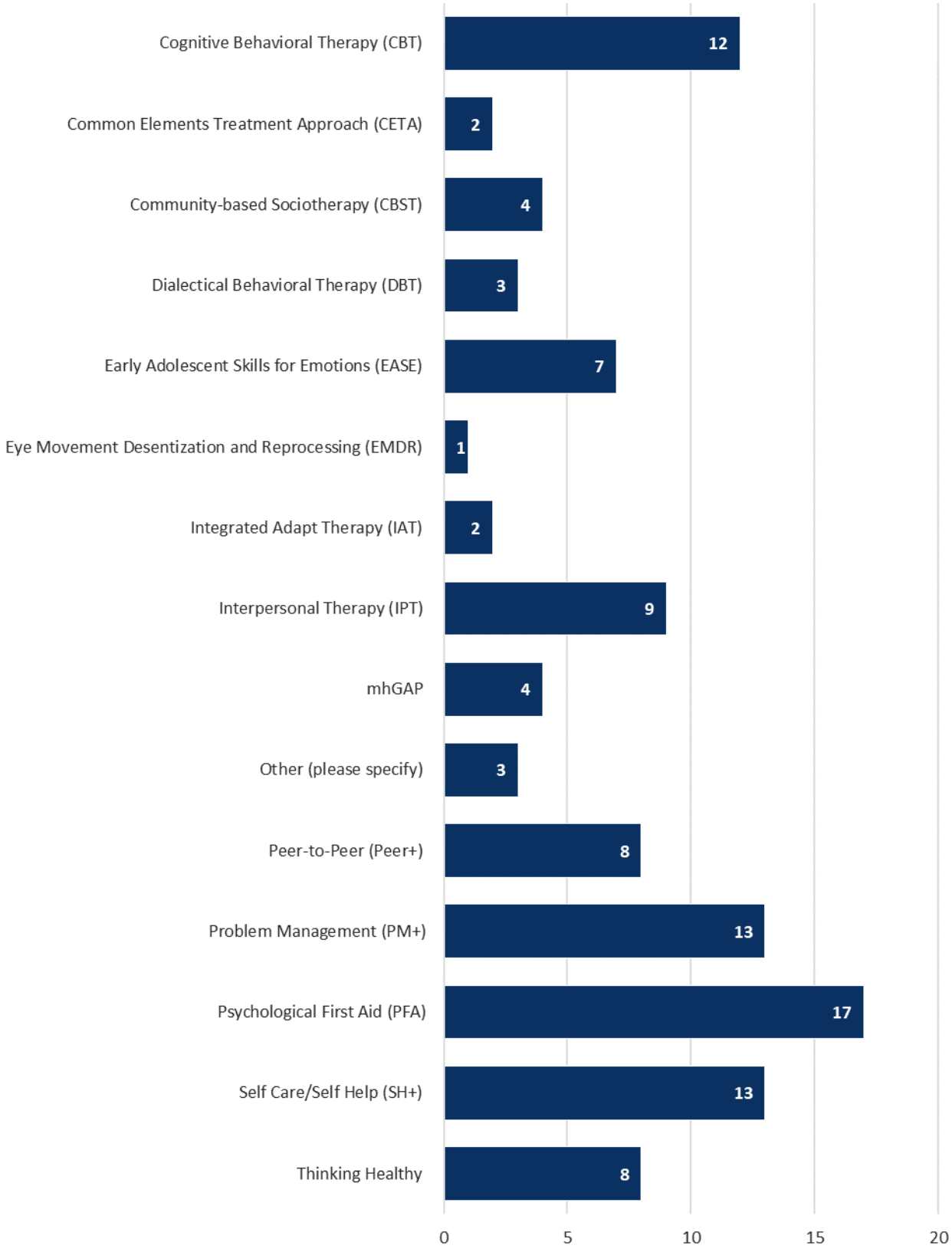


Table 22: Supporting data table for Exhibits 11 through 18 – Therapies offered as part of PRM-funded MHPSS programming by population

Therapy	Refugees in camps	Refugees outside of camps	Internally displaced persons (IDPs)	Stateless people	Returnees	Asylum seekers	Migrants	Local communities
Cognitive Behavioral Therapy (CBT)	4	14	3	1	1	8	3	12
Common Elements Treatment Approach (CETA)	0	1	1	1	0	1	1	2
Community-based Sociotherapy (CBST)	1	4	1	2	0	3	2	4
Dialectical Behavioral Therapy (DBT)	0	4	1	1	0	4	2	3
Early Adolescent Skills for Emotions (EASE)	2	9	2	1	1	5	3	7
Eye Movement Desentization and Reprocessing (EMDR)	0	3	1	0	1	2	0	1
Integrated Adapt Therapy (IAT)	1	3	1	2	0	3	3	2
Interpersonal Therapy (IPT)	2	8	1	3	0	6	3	9
mhGAP	3	5	1	0	1	2	1	4

Therapy	Refugees in camps	Refugees outside of camps	Internally displaced persons (IDPs)	Stateless people	Returnees	Asylum seekers	Migrants	Local communities
Other (please specify)	0	3	1	0	1	1	1	3
Peer-to-Peer (Peer+)	1	11	2	2	1	6	2	8
Problem Management (PM+)	6	15	3	3	1	8	4	13
Psychological First Aid (PFA)	7	20	4	3	3	12	8	17
Self Care/Self Help (SH+)	3	14	2	3	2	9	5	13
Thinking Healthy	0	9	2	1	1	5	3	8

Exhibit 19: Therapies offered for Anxiety Disorder as part of PRM-funded MHPSS programming

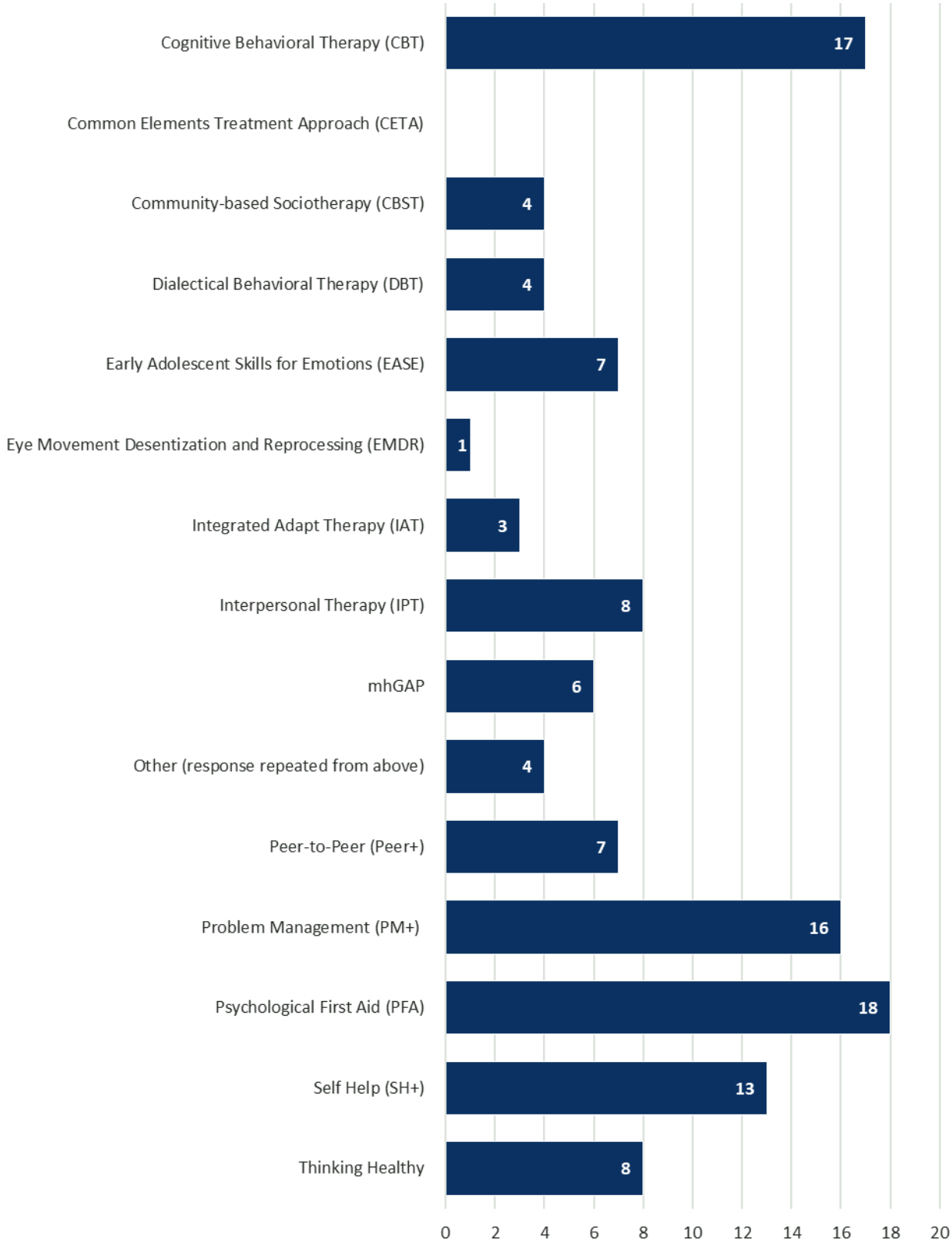


Exhibit 20: Therapies offered for Depression as part of PRM-funded MHPSS programming

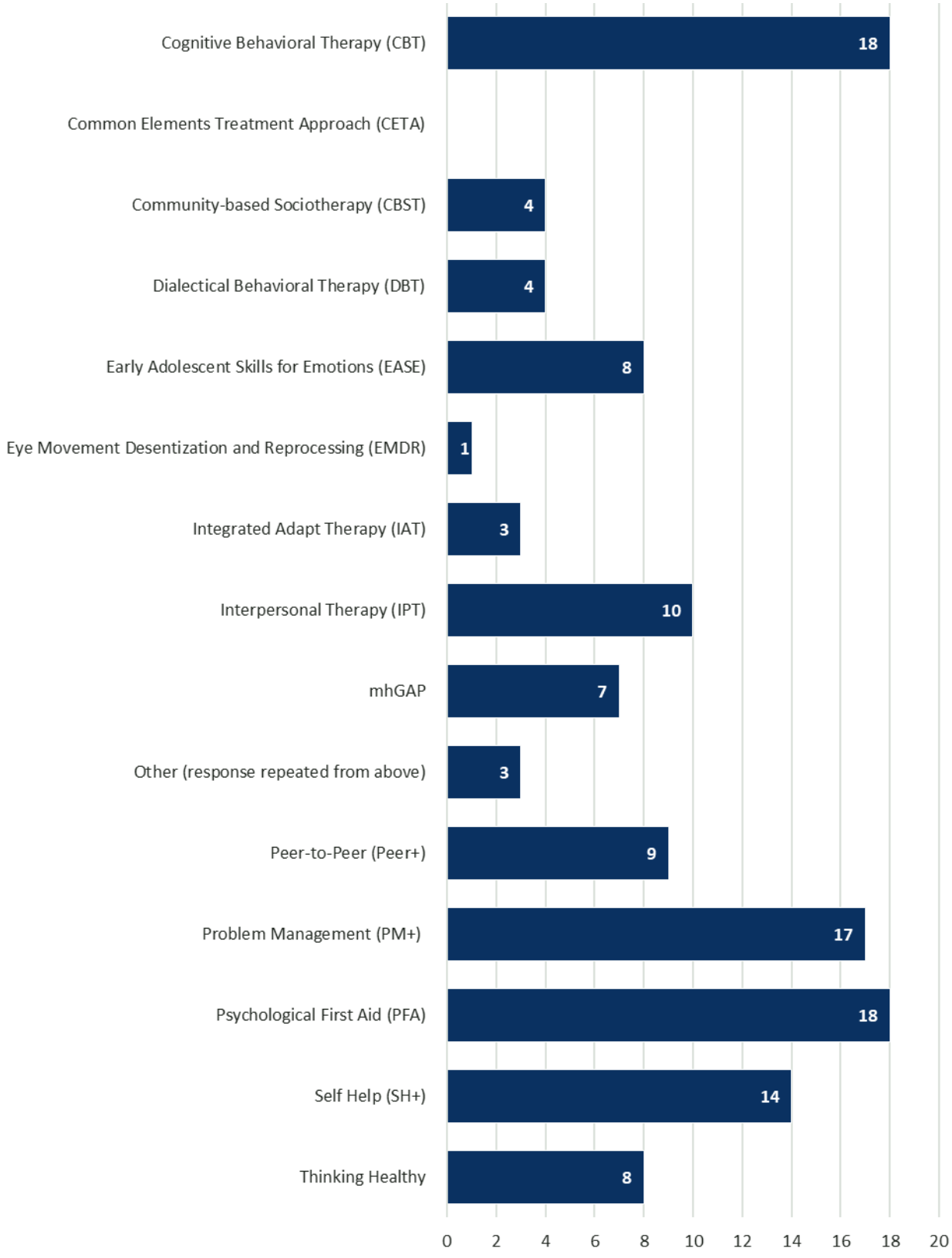


Exhibit 21: Therapies offered for Suicidal Ideation as part of PRM-funded MHPSS programming

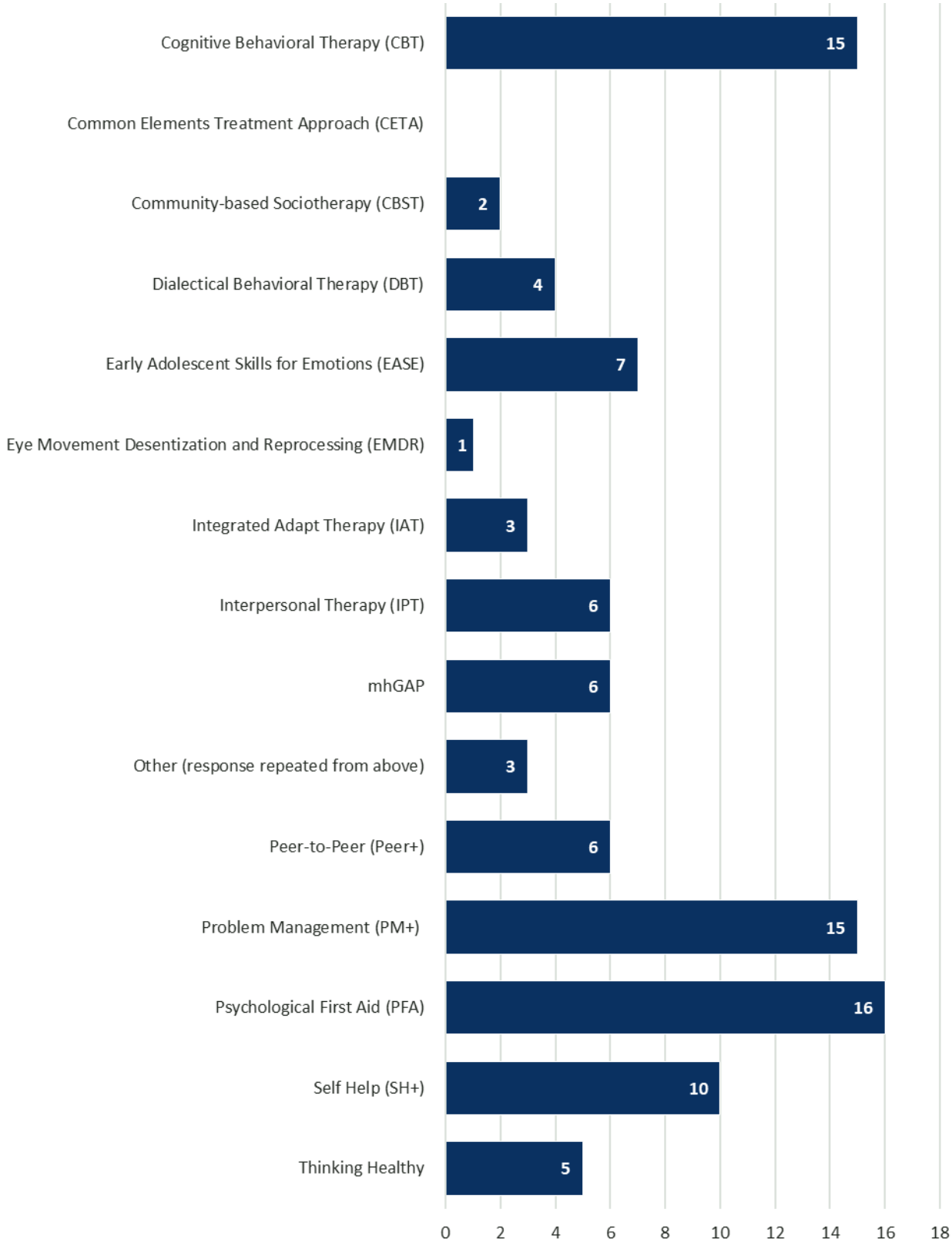


Exhibit 22: Therapies offered for Post-traumatic Stress Disorder as part of PRM-funded MHPSS programming

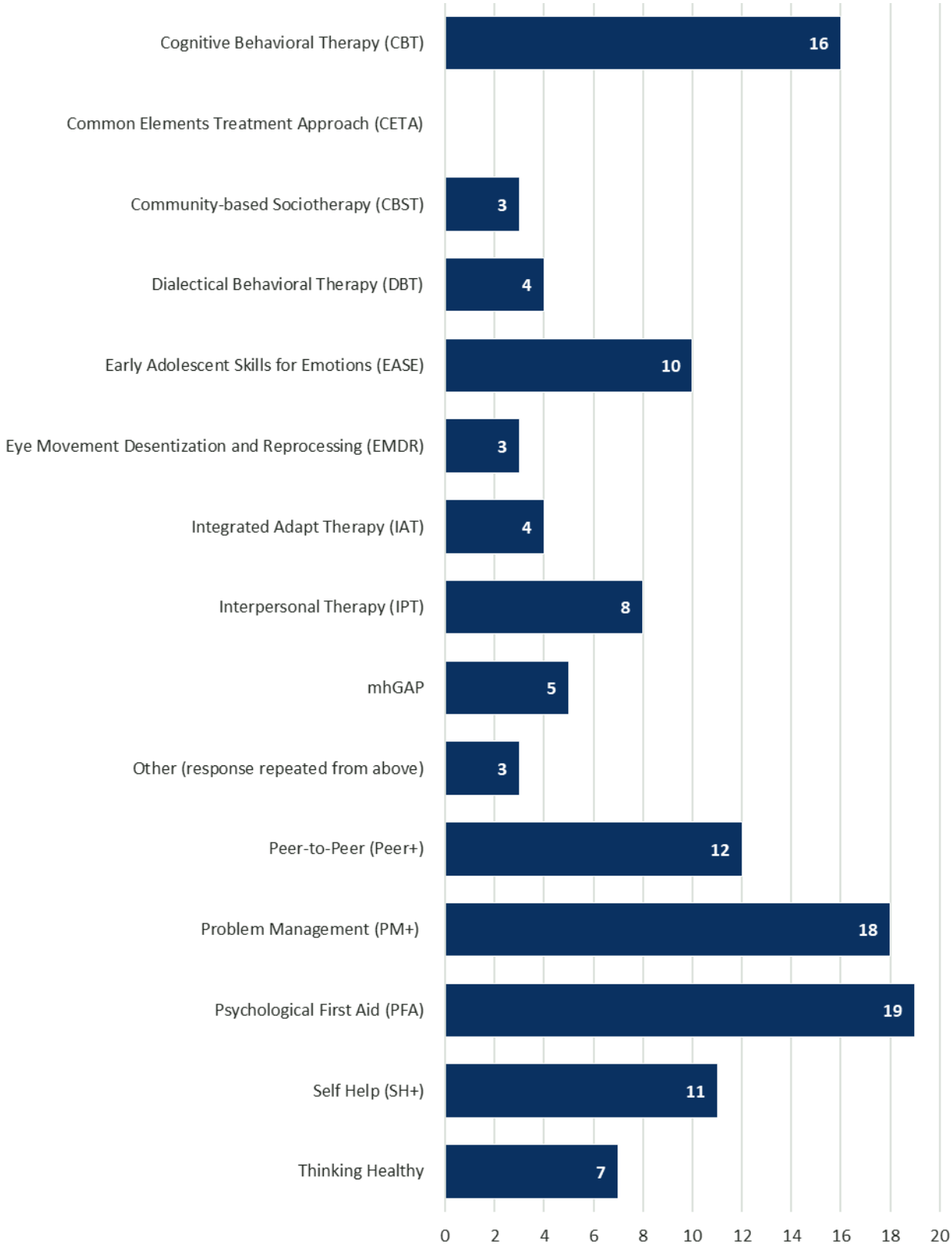


Exhibit 23: Therapies offered for Dementia as part of PRM-funded MHPSS programming

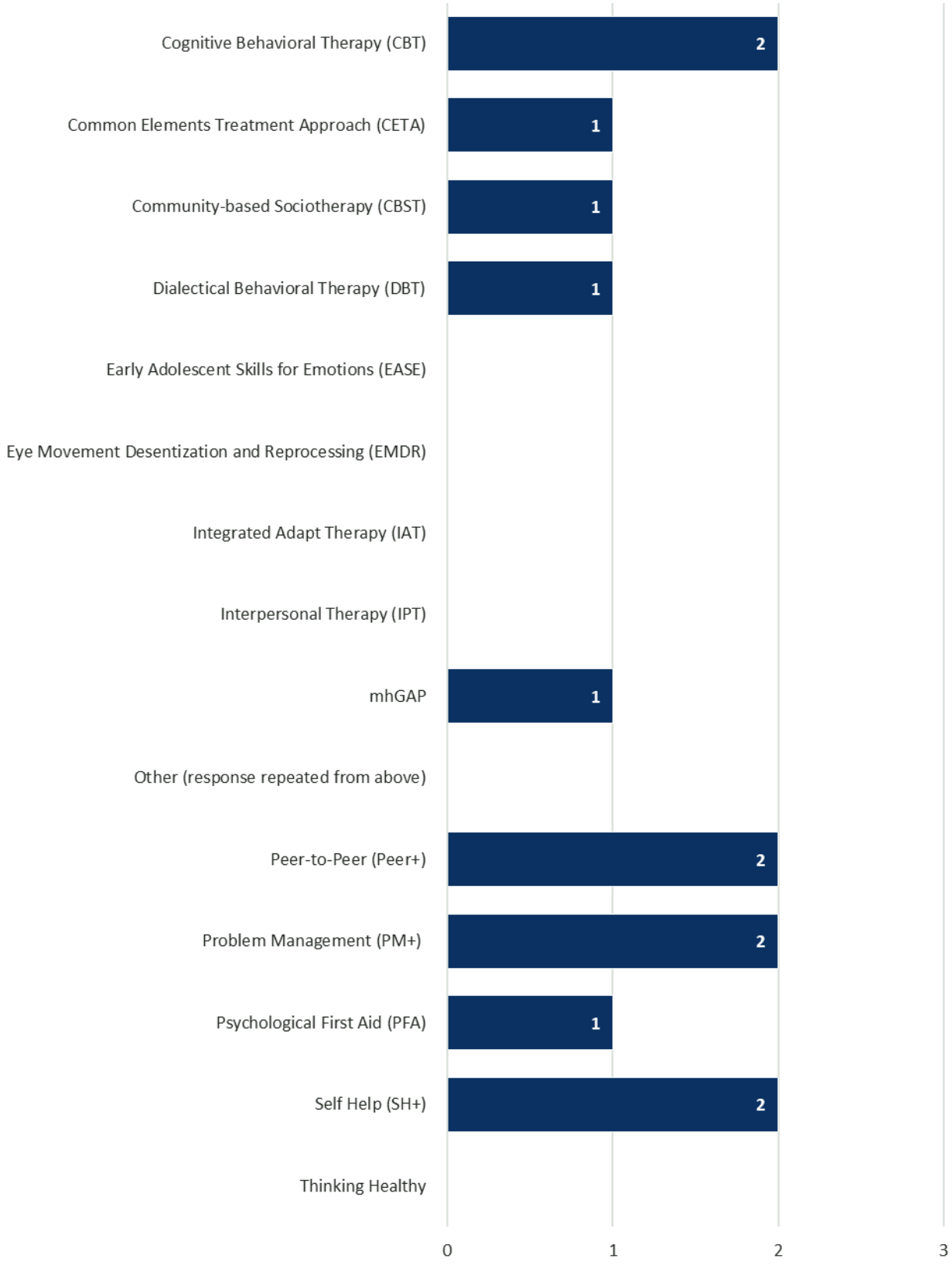


Exhibit 24: Therapies offered for Alcohol Addiction as part of PRM-funded MHPSS programming

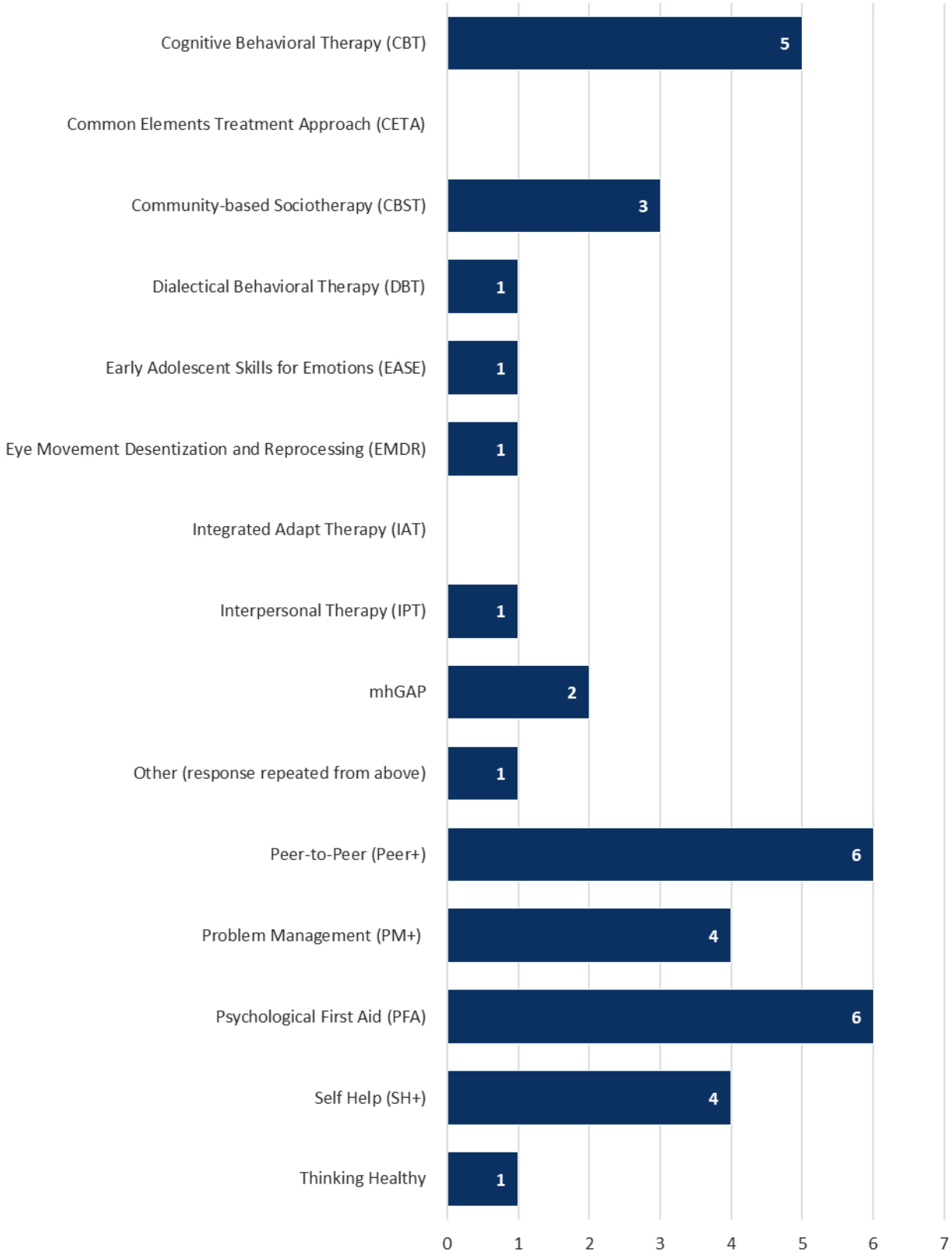


Exhibit 25: Therapies offered for Drug Addiction as part of PRM-funded MHPSS programming

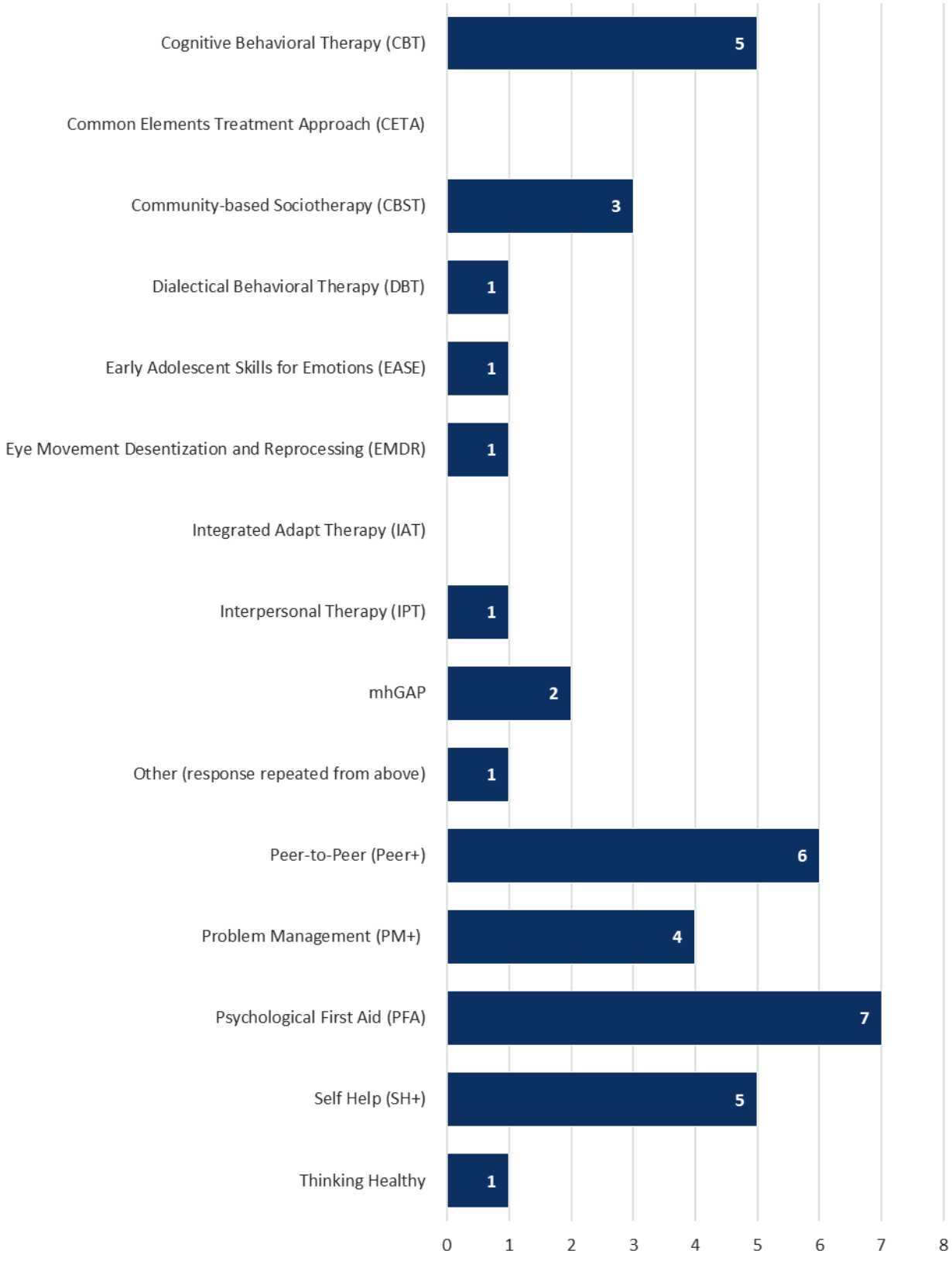


Table 23: Supporting data table for Exhibits 19 through 25 – Therapies offered for clinical disorders as part of PRM-funded MHPSS programming

Therapy	Anxiety disorder	Depression	Suicide Ideation	Post-Traumatic Stress Disorder (PTSD)	Dementia	Alcohol Addiction	Drug Addiction
Cognitive Behavioral Therapy (CBT)	17	18	15	16	2	5	5
Common Elements Treatment Approach (CETA)	0	0	0	0	1	0	0
Community-based Sociotherapy (CBST)	4	4	2	3	1	3	3
Dialectical Behavioral Therapy (DBT)	4	4	4	4	1	1	1
Early Adolescent Skills for Emotions (EASE)	7	8	7	10	0	1	1
Eye Movement Desentization and Reprocessing (EMDR)	1	1	1	3	0	1	1
Integrated Adapt Therapy (IAT)	3	3	3	4	0	0	0
Interpersonal Therapy (IPT)	8	10	6	8	0	1	1
mhGAP	6	7	6	5	1	2	2

Therapy	Anxiety disorder	Depression	Suicide Ideation	Post-Traumatic Stress Disorder (PTSD)	Dementia	Alcohol Addiction	Drug Addiction
Other (response repeated from above)	4	3	3	3	0	1	1
Peer-to-Peer (Peer+)	7	9	6	12	2	6	6
Problem Management (PM+)	16	17	15	18	2	4	4
Psychological First Aid (PFA)	18	18	16	19	1	6	7
Self Help (SH+)	13	14	10	11	2	4	5
Thinking Healthy	8	8	5	7	0	1	1

Exhibit 26: Frequency of organizations' PRM-funded MHPSS programming responding to MHPSS clinical disorders across all populations

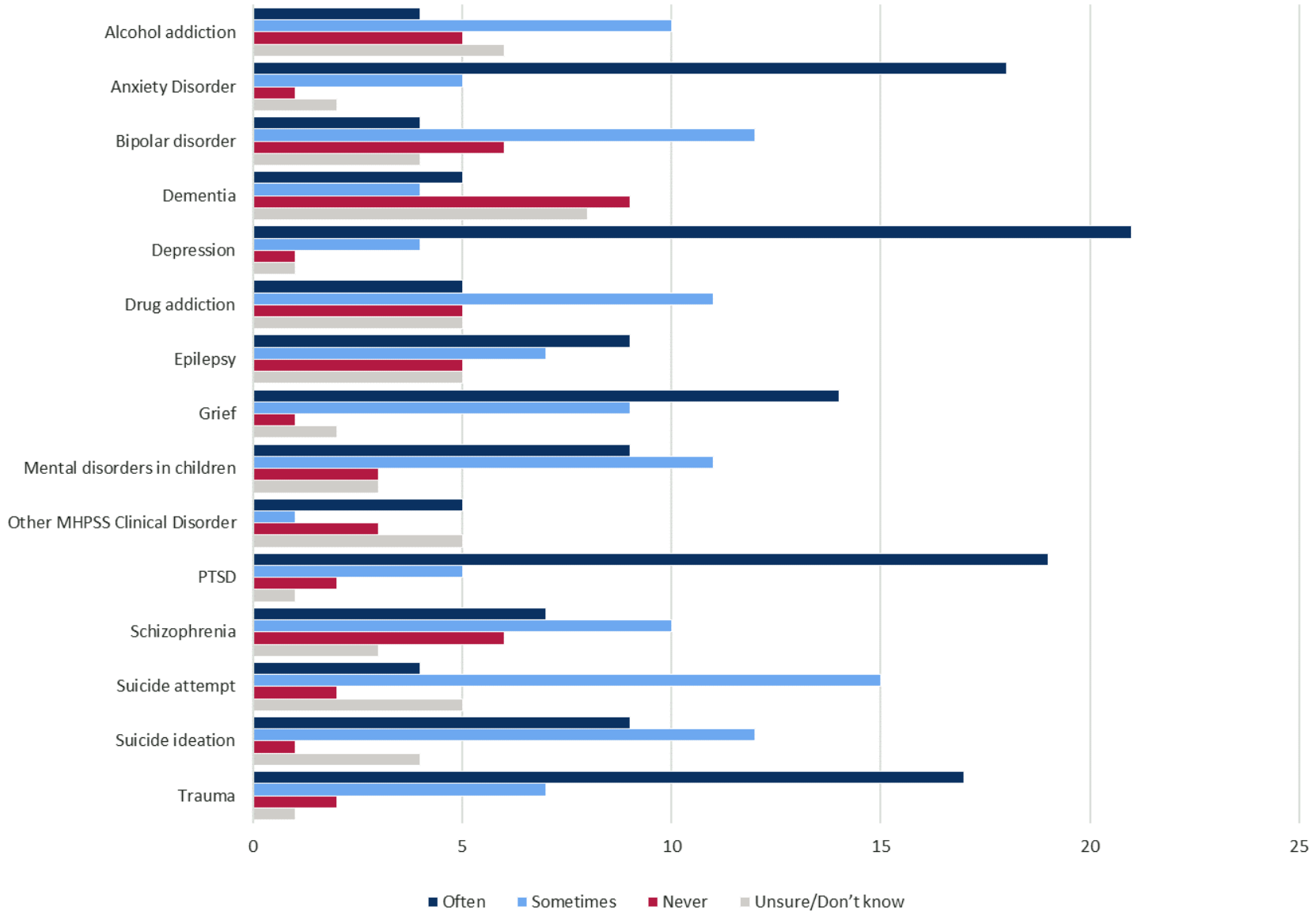


Table 24: Supporting data table for Exhibit 26 – Frequency of organizations' PRM-funded MHPSS programming responding to MHPSS clinical disorders across all populations

Clinical disorder	Often	Sometimes	Never	Unsure/Don't know
Alcohol addiction	4	10	5	6
Anxiety Disorder	18	5	1	2
Bipolar disorder	4	12	6	4
Dementia	5	4	9	8
Depression	21	4	1	1
Drug addiction	5	11	5	5
Epilepsy	9	7	5	5
Grief	14	9	1	2
Mental disorders in children	9	11	3	3
Other MHPSS Clinical Disorder	5	1	3	5
PTSD	19	5	2	1
Schizophrenia	7	10	6	3
Suicide attempt	4	15	2	5
Suicide ideation	9	12	1	4
Trauma	17	7	2	1

Exhibit 27: Frequency of organizations' PRM-funded MHPSS programming responding to MHPSS health concerns across all populations

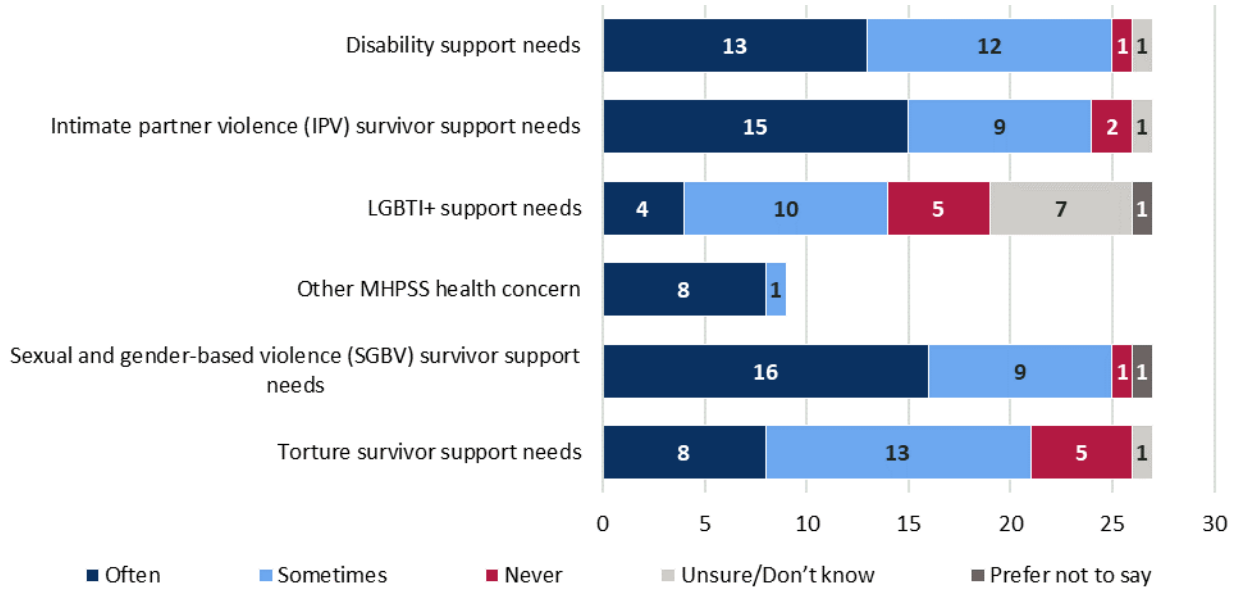


Table 25: Supporting data table for Exhibit 27 – Frequency of organizations' PRM-funded MHPSS programming responding to MHPSS health concerns across all populations

Health concerns	Often	Sometimes	Never	Unsure/Don't know	Prefer not to say
Disability support needs	13	12	1	1	0
Intimate partner violence (IPV) survivor support needs	15	9	2	1	0
LGBTI+ support needs	4	10	5	7	1
Other MHPSS health concern	8	1	0	0	0
Sexual and gender-based violence (SGBV) survivor support needs	16	9	1	0	1
Torture survivor support needs	8	13	5	1	0

Exhibit 28: Methods used by organizations as part of PRM-funded MHPSS programming to consult beneficiaries to integrate their perspectives into MHPSS programming

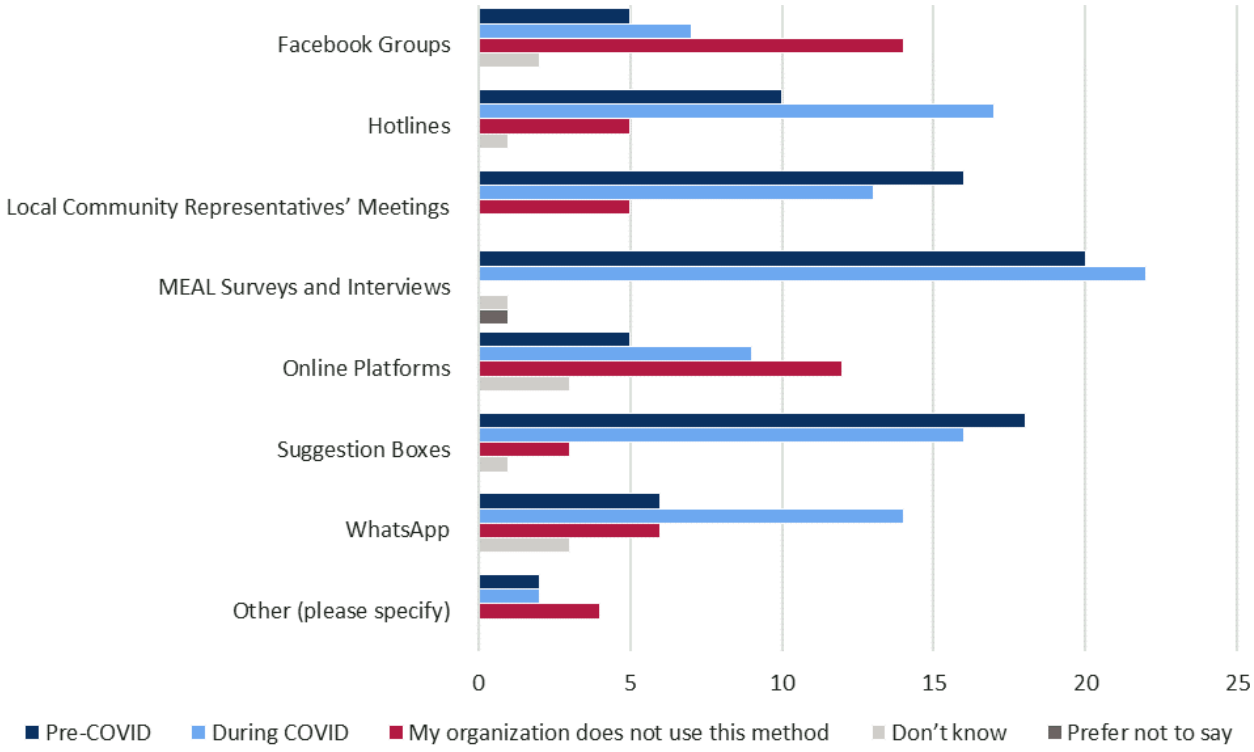


Table 26: Supporting data table for Exhibit 28 – Methods used by organizations as part of PRM-funded MHPSS programming to consult beneficiaries to integrate their perspectives into MHPSS programming

Consultation methods	Pre-COVID	During COVID	My organization does not use this method	Don't know	Prefer not to say
Facebook Groups	5	7	14	2	0
Hotlines	10	17	5	1	0
Local Community Representatives' Meetings	16	13	5	0	0
MEAL Surveys and Interviews	20	22	0	1	1
Online Platforms	5	9	12	3	0
Suggestion Boxes	18	16	3	1	0

Consultation methods	Pre-COVID	During COVID	My organization does not use this method	Don't know	Prefer not to say
WhatsApp	6	14	6	3	0
Other (please specify)	2	2	4	0	0

Exhibit 29: Interventions made by organizations to address MHPSS staff needs during the COVID-19 pandemic

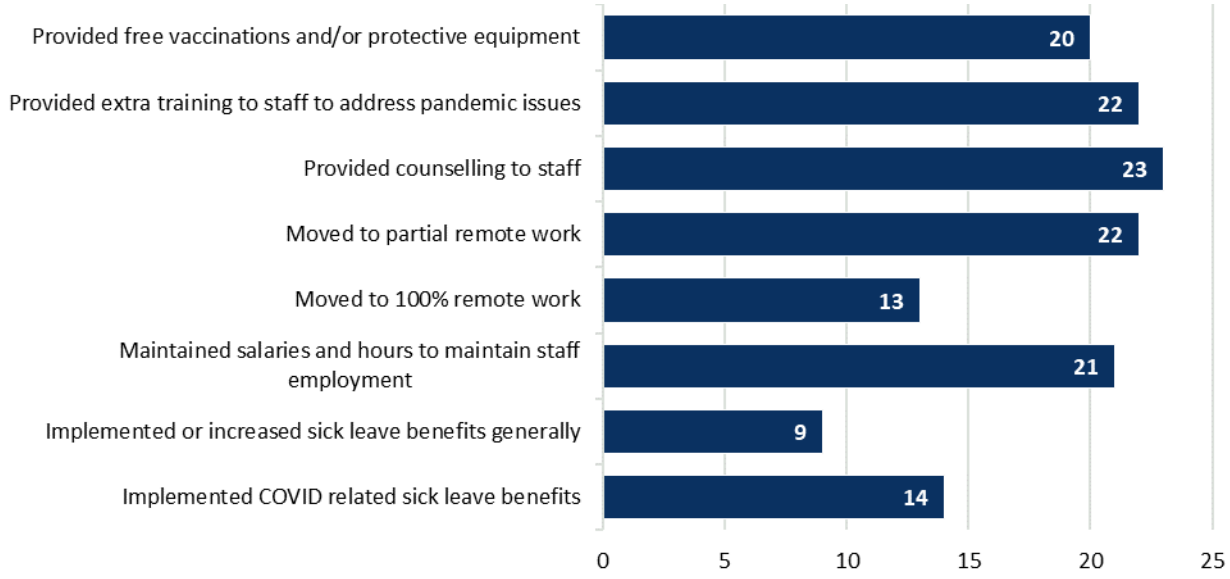


Table 27: Supporting data table for Exhibit 29 – Interventions made by organizations to address MHPSS staff needs during the COVID-19 pandemic

Intervention	Number of responses
Provided free vaccinations and/or protective equipment	20
Provided extra training to staff to address pandemic issues	22
Provided counselling to staff	23
Moved to partial remote work	22
Moved to 100% remote work	13
Maintained salaries and hours to maintain staff employment	21
Implemented or increased sick leave benefits generally	9
Implemented COVID related sick leave benefits	14

Annex 10: PRM standard MPHSS Indicators for NGOs

Overarching protection/MHPSS indicator required for all PRM programs:

- (Outcome) Percentage of beneficiaries who report an improved sense of safety and well-being at the end of the program, disaggregated by age and gender.

MHPSS specific indicators

- (Output) Number of patients receiving psychological first aid.
- (Output) Number of teachers trained in and receiving follow-up support on how to support learners' psychosocial well-being.
- (Output) Percentages of medical facilities, social services facilities, and community programs that have staff trained to identify mental disorders and to support people with mental health and psychosocial problems.
- (Outcome) Percentage of people satisfied with mental health and psychosocial care they or their families receive.

Endnotes

[a] United Nations High Commissioner for Refugees (UNHCR) (2021a) Refugee Data Finder: Key Indicators.

[b] WHO (2021) Mental Health Atlas 2020. Geneva.

[c] Riley, Andrew, Yasmin Akther, Mohammed Noor, fourth author redacted, and Courtney Welton-Mitchell (2021). Mental health and conditions in refugee camps matter when Rohingya living in Bangladesh consider returning to Myanmar. May 10, 2021. Humanitarian Practice Network.

[d] WHO (2021) Mental Health Atlas 2020. Geneva.

[e] Riley, Andrew, Yasmin Akther, Mohammed Noor, fourth author redacted, and Courtney Welton-Mitchell (2021). Mental health and conditions in refugee camps matter when Rohingya living in Bangladesh consider returning to Myanmar. May 10, 2021. Humanitarian Practice Network.

[f] United Nations High Commissioner for Refugees (UNHCR) (2021a) Refugee Data Finder: Key Indicators.; IOM (2021) Early marriage. Awareness or Psychoeducation Session, MHPSS Team, Cox's Bazar

[g] WHO and UNHCR (2015) mhGAP Humanitarian Intervention Guide. Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies. Geneva.

[h] Charlson F, et al. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. Lancet. 2019 Jul;394(10194):240–8.; UNHCR (2021c) Strengthening Mental Health and Psychosocial Support in 2021. UNCHR, Geneva.

[i] Inter-Agency Standing Committee (IASC), Geneva. (2017). Reference Group for Mental Health and Psychosocial Support in Emergency Settings, A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings

[j] The Mental Health and Psychosocial Support Minimum Services Package https://mhpssmsp.org/en

[k] DOS Congressional Budget Justification FY2022:95

[l] Sagar-Ouriaghli, I., E. Godfrey, L. Bridge, L. Meade, and J.S.L. Brown. (2019). Improving Mental Health Utilization Among Men: A Systematic Review and Synthesis of Behavior Change Techniques Within Interventions Targeting Help Seeking. American Journal of Mens Health 13(3). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6560805/

[m] Acarturk, C., E. Uygun, Z. Ilkkursun, K. Carswell, F. Tedeschi, M. Batu, S. Eskici, G. Kurt, M. Anttila, T. Au, J. Baumgartner, and R. Churchill. (2022a) Effectiveness of a WHO self-help psychological intervention for preventing mental disorders among Syrian refugees in Turkey: a randomized control trial. World Psychiatry. 11 January 2022

[n] Acarturk, C., E. Uygun, Z. Ilkkursun, T. Yurtbakan, G. Kurt, J. Adam-Troian, I. Senay, R. Bryant, P. Cuijpers, N. Kiselev, D. McDaid, N. Morina, Z. Niscanci, A.L. Park, M. Sijbrandiji, P. Ventevogel, and D.C. Fuhr. (2022b). Group problem mangaemnt plus to decrease psychological distress among Syrian refugees in Turkey: a pilot randomised controlled trial. BMC Psychiatry. 04 January 2022.

[o] Tay, A.K. H.K. Mung, M.A.A Miah, S. Balasundaram, P. Ventevogel, M. Badrudduza, S. Khan, K. Morgan, S. Rees, M. Mohsin, and D. Silove. (2020). An Integrative Adapt Therapy for common mental health symptoms and adaptive stress amongst Rohingya, Chin, and Kachin refulgees living in Malaysia: A randomized controlled trial. Plos Medicine, published 31 March 2020. https://doi.org/10.1371/journal.pmed.1003073

[p] UNHCR (2020). COVID-19 Emerging Practices on Livelihoods and Economic Inclusion, published May 2020.

[q] PRM (2018). Policy and Program Review Committee (PPRC): FY 2018-FY 2021 Health Strategy Paper. Sensitive But Unclassified Memorandum.

[r] Fortify Rights (2020). The Torture in My Mind: The Right to Mental Health for Rohingya Survivors of Genocide in Myanmar and Bangladesh, US and Switzerland

[s] WHO (2020) Doing What Matters in Times of Stress: An Illustrated Guide. Geneva

[t] Harrison, S., Hanna, F. Ventevogel, P., Polutan-Teulieres, N & Chemaly, W.S. (2020). MHPSS and protection outcomes: Why joint action to improve mental health and psychosocial wellbeing of people affected by conflict, violence and disasters should be a priority for all protection actors - Policy Discussion Paper. Geneva, Global Protection Cluster and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings.

[u] Harrison, Sarah et al. (2020) MHPSS-and-Protection outcomes. Global Protection Cluster and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. Policy Discussion Paper, September 2020, Geneva. https://www.globalprotectioncluster.org/wp-content/uploads/MHPSS-and-Protection.pdf

[v] Inter-Agency Standing Committee (IASC) (2021). IASC Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings: With means of verification (Version 2.0) https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common-monitoring-and-evaluation-framework-mental-health-and-psychosocial-support-emergency

[w] Chisholm, Dan on behalf of WHO-Choice (2005) Choosing cost-effective interventions in psychiatry: results from the CHOICE programme of the World Health Organization. World Psychiatry. Vol. 4(1) 2005 February

[x] WHO (2013) Building Back Better: Sustainable Mental Health Care after Emergencies. Geneva.

[y] Department of State (2021) Congressional Budget Justification: Department of State, Foreign Relations, and Related Programs, FY2022. https://www.state.gov/wp-content/uploads/2021/05/FY-2022-State_USAID-Congressional-Budget-Justification.pdf